Prescription Drugs: Market Pricing or Government Subsidies? — Pages 10-11

Health Care News

©2001 The Heartland Institute | The Monthly Newspaper for Health Care Reform | Vol. 1 No. 8 ~ November 2001

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# Doctors Support Market-Based Health Care

## *State medical association rejects single-payer measures*

**BY CONRAD F. MEIER**

At the Washington State Medical Association's (WSMA) annual meeting in early October, a majority of some 200 doctors present voted to continue supporting the existing market-based health care system, while still striving for universal coverage.

The group resisted the call by some physicians to push for a new health care system in Washington—one in which the state would tax businesses and residents to pay for all health services in a plan often described as "everyone in, no one out."

Such a single-payer health system, promoted by the Health Care 2000 coalition, would replace not only private health care arrangements in the state, but the public health insurance system as well.

### Thumbs Up for MSAs

Reiterating its support for universal health care coverage, the WSMA said such coverage should include:

DOCTORS continued on page 9

Broward County, Florida, technicians Mike Silvestri and Neil Colosi finish checking out a mail box where a postal worker discovered a powdery substance. PHOTO: Mike Stocker/ South Florida Sun-Sentinel. See story on page 14.

# Bush Seeks Billions in Federal Health Insurance Subsidies

**BY CONRAD F. MEIER**

President George W. Bush called on Congress to approve $3 billion in "emergency grants" to states to assist workers who were laid off following the September 11 attacks on the World Trade Center and the Pentagon. Bush also wants to allow states to use $11 billion in unused federal funds available through the Children's Health Insurance Program to help those affected by the attacks.

States could use the federal grants plan—which coincides with a larger economic stimulus plan under consideration by Congress—to pay up to 75 percent of displaced workers' COBRA health insurance premiums for up to 12 months. Under COBRA, employees who are laid off or leave their jobs can retain their insurance coverage but must pay 102 percent of the premium—a price often prohibitive for those without a steady income.

The states would also be permitted to use the grants for unemployment payments or job training. The Labor Department announced in October new claims for state unemployment insurance jumped to 528,000—"the highest level in more than nine years," according to the *New York Times*.

### S-CHIP Fund Flexibility

Bush told members of the press, "[HHS Secretary] Tommy Thompson said there's

SUBSIDY continued on page 13

# *Tennessee Employers May Face "Play or Pay"*

**BY CONRAD F. MEIER**

At the close of this year's legislative session, cash-strapped Tennessee lawmakers failed to balance the budget on the back of taxpayers. They were told by the state's residents, in no uncertain terms, "no new taxes." (See "Tennessee Taxpayers Revolt," *Health Care News*, August 2001.)

But higher taxes may lie ahead if businesses, commercial insurers, and health care providers are forced to either participate (play) in TennCare or subsidize it (pay) could emerge as a divisive issue in the Volunteer State's next legislative session, which convenes January 9, 2002.

Governor Don Sundquist (D) recently offered his qualified support for "play or pay" in a press conference, stating, "Clearly, we have to figure out some way for insurance companies to either participate by covering people and not shifting them to TennCare, or they ought to share in the cost of people who are shifted." The governor said TennCare "ought not to be the only insurance policy in the state."

The trick, the governor said, is to use a carrot to draw more businesses, health care providers, and insurers to TennCare, rather than use a stick to force those entities to underwrite the program. "We don't want to mandate to them, but we need them to participate, and where they don't they ought to help us in other ways," Sundquist said.

Deputy Finance Commissioner John Tighe said the state has not taken a firm position on play or pay at this point, "but we do embrace the idea that all who benefit from TennCare should also contribute to the program."

### Follow the Money

Play or pay could gain momentum as the General Assembly seeks some kind of plan to overcome a projected $130 million revenue shortfall for the current fiscal year.

"It's an idea that's too logical to ignore," said Ron Harr, vice president of communications at

TENNESSEE continued on page 7

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**MY TURN**

*AN EDITORIAL BY CONRAD MEIER*

*Stop Demonizing the Good Guys* p.18

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Chicago, IL 60603

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Health Care News

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Health Care News is published 12 times per year by The Heartland Institute. Subscriptions are free to U.S residents and $24 per year for foreign residents. Order online at www.heartland.org. Heartland is a nonprofit and nonpartisan public policy research organization serving the nation's federal and state elected officials, journalists, Heartland Members, and other opinion leaders. Its activities are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

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# New York Doctors Sue HMOs

**BY VICKI LANKARGE**

The Medical Society of the State of New York (MSSNY), on behalf of its 27,000 physician members, has sued six major HMOs for allegedly engaging in wrongful practices—including the arbitrary denial of "medically necessary" care, breach of contract with doctors, and the use of computer programs to automatically reduce or deny claims.

The six separate lawsuits name Aetna, CIGNA, Empire Blue Cross and Blue Shield, Excellus, Oxford, and UnitedHealthCare. They echo claims made in similar lawsuits against health plans that are now pending before a federal judge in Miami, who must decide whether to grant the lawsuits class action status or dismiss the cases entirely.

The MSSNY lawsuits were filed August 15, 2001, in New York State Supreme Court. They request that the court put an end to "destructive, ongoing practices by managed care insurance carriers." Individual doctors, who are MSSNY members, also filed six separate lawsuits against the same insurers, seeking class action status and undisclosed monetary damages.

> **"If the Medical Society and its doctors are truly concerned about patient care, they would use their considerable resources on efforts to improve overall quality of care and reduce medical errors."**
>
> **PAUL MACIELAK, PRESIDENT**
> **NEW YORK HEALTH PLAN ASSOCIATION**

MSSNY President Dr. Robert Bonvino says the legal actions are "the culmination of years of intransigence by the managed care insurance carriers." Additionally, he says "thousands of doctors across New York State, and across the country, are forced to deal as individuals with these multibillion-dollar monoliths which have assumed control over our lives, the lives of our patients, and the practice of medicine."

But the MSSNY lawsuits are not about protecting patients, say insurance industry insiders. "It is clearly a copycat action aimed at enriching doctors' pocketbooks," says Paul Macielak, president of the New York Health Plan Association, an HMO umbrella group to which Aetna, CIGNA, Oxford, and UnitedHealthCare belong. "If the Medical Society and its doctors are truly concerned about patient care, they would use their considerable resources on efforts to improve overall quality of care and reduce medical errors."

### Familiar Charges

The allegations outlined in the lawsuits have become familiar. Among them are allegations that the insurers:

- Arbitrarily reduce a physician's payment for medically necessary care by "downcoding," or changing claims and billing codes to indicate a doctor should be paid less. For example, a doctor conducts an extensive office visit with a patient who has a number of health problems, but is reimbursed only for a simple office visit that is far shorter and less complicated.
- Bundle claims, or issue a single payment for a group of related medical services, rather than paying for each service individually.
- Arbitrarily overrule a physician's determination of medical necessity without conducting a proper analysis or review.
- Fail to pay physicians in a timely fashion.
- Fail to pay interest on overdue claims payments, in accordance with the state's prompt payment law.
- Force physicians and their staffs to expend an unreasonable amount of time and resources attempting to obtain reimbursement to which they are entitled.
- Exploit the doctors' unequal bargaining power to force physicians to enter into one-sided HMO contracts.

*Vicki Lankarge is a reporter for insure.com The Consumer Insurance Guide.*

## *Number of Viable Stem Cell Lines Lower than Thought*

**BY CONRAD F. MEIER**

In August, when President George W. Bush announced his limited support for stem-cell research, he indicated more than "60 genetically diverse stem-cell lines already exist." Driven by skepticism in scientific quarters, the National Institutes of Health (NIH) researched the President's claim and identified the location of 64 stem-cell lines.

It appears now, however, that the NIH count may have been wrong, and far fewer than 64 cell lines may be available for researchers.

### Half as Many?

Health and Human Services Secretary Tommy Thompson has confirmed in Senate hearings there may be fewer than 30 "diverse, robust and viable [cell lines] for research." That number, according to many researchers, is not enough to ensure the wide-ranging research promised by Bush.

Getting an accurate count of the number of cell lines available is a key element in the public policy debate over stem-cell research. The amount of funding Congress will approve for research is likely to depend on the number of lines available, and that funding could be inadequate if fewer lines are available than expected. Moreover, legislation barring many potential methods for creating new stem-cell lines may be inappropriate if the current number of cell lines is low.

The President was adamant that federal funding for stem-cell research would be available only for research employing stem cells collected by August 9, 2001 from "excess" embryos donated by fertility clinics. But foreign governments have no such restrictions on the collection of stem cells. Bush's decision likely means researchers seeking federal government funding would be prohibited from taking advantage of foreign-source cell lines. Research could be further stifled by the business goals of some stem-cell line owners, and by the possibility that available cell lines could "crash" for reasons unknown.

### Administration Spin

HHS Secretary Thompson, in an opinion essay, reminded *USA Today* readers that the "administration made it clear the 64 stem-cell lines were in various stages of development and that they are all eligible for federal funding."

He also noted "there are ample stem-cells for basic research." He pointed out the Wisconsin Alumni Research Foundation owns five stem-cell lines … and the discoveries the Foundation has made to date come from just two of those lines. In the short term, then, the apparent shortfall in cell lines shouldn't delay research.

But it's also important to note that fewer stem-cell lines means less genetic diversity, raising the possibility important research may not be forthcoming.

It would appear the stem-cell research debate is far from over. At best, federal government agencies won't be ready to start giving research grants until next year … and the events of September 11 are likely to keep the issue on the back burner for months to come.

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# The Pulse

## Free-market health care reform in the news

BY GREG SCANDLEN

The Census Bureau released in early October a revised report on the count of uninsured for the year 2000. By using a new methodology that eliminates some of the misreporting of the past, the Census Bureau now finds the number of uninsured dropped fairly substantially from 1999, making the second year in a row the count has gone down.

Also in the report:

- People covered by employment-based coverage increased from 63.5 percent of the population in 1999, to 64.1 percent in 2000.
- The percentage of people covered by government insurance actually decreased slightly, from 24.3 percent to 24.2 percent.
- People generally are getting wealthier. The total population with incomes below $25,000 dropped from 64.6 million in 1999 to 61.1 million in 2000. The population with incomes of $25,000 to $49,999 dropped from 77.1 million to 75.4 million. The number of people with higher incomes increased from 132.6 million to 140 million.
- Non-insurance continues to be a particular problem for the foreign-born, the young, and Hispanics.
- The percentage of uninsured children dropped from 12.6 in 1999 to 11.6 in 2000, but the improvement was due to the increase in employment-based coverage. The report says, "no change occurred in government health insurance coverage." Poor children are nearly twice as likely to be uninsured as non-poor children (21.5 percent to 11.6 percent), reflecting the failure of the SCHIP program.

None of these numbers is very reliable in any event. They count on self-reporting of things that happened over a year ago, and have been plagued by exaggeration. But they do provide a frame of reference for discussing the issue.

Source: There are plenty of mainstream media reports, but to get the source material, go to: http://www.census.gov/hhes/www/hlthin00.html

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FAMILIESUSA: TAX CREDITS WON'T HELP

Reflecting the fanaticism of the Left on health issues, FamiliesUSA went ahead and released its new report on tax credits the day after the terrorist attacks, September 12.

Snidely titled, "A 10-Foot Rope for a 40-Foot Hole," the report pretends to show how a $1,000 tax credit would be of little value to the uninsured. It defines a "standard" plan as the Blue Cross Blue Shield Standard Option under FEHBP. This plan has a $250 deductible, 10 percent medical coinsurance, prescription drug coverage with no more than a 25 percent coinsurance, and an annual stop-loss of $3,000. No plan with a higher deductible or more than 20 percent coinsurance was considered, or was labeled "substandard."

The report's first finding was, "$1,000 plans are not always available for healthy, non-smoking, 25-year-old women." Actually, the real news should have been that such plans are available for this price in 19 of the 25 states studied.

Of course, no one has suggested that a $1,000 tax credit would, or should, pay 100 percent of the premium for anyone.

Source: http://www.familiesusa.org

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*EBN* ON DEFINED CONTRIBUTION

*Employee Benefit News* has run the second of its two-part series by Jill Elswick on defined contribution. This installment describes five business models as laid out by the Coalition on Consumer Driven Health Care, and mentions which of the new vendors are following which models.

The models are called: Decision Support (offered by Definity Health, Lumenos, and Sageo), Benefit Design (Destiny Health and Choicelinx), Health Plan Catalog (MyHealthBank), Time-of-Need Network (HealthAllies and HealthMarket), and Advanced Selection (Vivius and the Buyers Health Action Coalition).

The news coming out of the article is that the Choicelinx product will be offered by Morgan Stanley to 10,000 employees in Arizona, Utah, and Ohio.

Source: http://www.benefitnews.com/pfv.cfm

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WASHINGTON DOCS OPPOSE SINGLE PAYER

The Washington State Medical Association has "resisted the call" to set up a single-payer system in Washington, according to an article by Peter Neurath in the *Puget Sound Business Journal*. The group instead has decided to support repealing state mandates, refundable tax credits, and expanding MSAs. (See story, page 1.)

The emphasis on mandated benefits comes from a task force created by the association that concluded, "Today, everyone wants everything to be covered by insurance. As a result, insurance products are laden with a host of mandated providers and mandated coverages." Past president of the association, Dr. Nancy Auer, said, "What is the value to society when in 2000 Regence Blue Shield paid out more for massage therapy than for oncology services?"

Source: http://seattle.bcentral.com/seattle/stories/2001/10/01/newscolumn4.html

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CU HATES MSAs, LOVES SCHIP

From the "Come Again?" Department: *Consumers Reports* proudly announces how its parent organization, Consumers' Union, is protecting consumers by fighting against medical savings accounts and tax credits, and fighting for expanding government programs like SCHIP and Medicaid.

Source: http://www.consumerreports.org/

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FROM THE CANADIAN PRESS ON MSAs

Speaking of MSAs, we've been saving up some articles from our friends to the North. As much as Consumers' Union would like to have a Canadian-type system here in the States, Canada seems to be running away from it as fast as it can. These articles may be difficult to link to, so I'll just give the regular citations:

- The *Ottawa Citizen* reports that the Senate Social Affairs Committee, chaired by Liberal Party member Michael Kirby, has released a 138-page report on the health of Canadians. On health care financing, its suggestions include: installing MSAs, charging premiums, and requiring the government system to pay for private-sector services under certain circumstances.

Source: "Dr. Kirby's Cure," *The Ottawa Citizen*, September 21, 2001

- But according to the Canada Newswire, the Canadian Union of Public Employees (CUPE) isn't buying it. They say Senator Kirby has a hidden agenda, and the report would result in a "two-tiered" health care system.

Source: "Kirby Report Offers More Than Issues and Options: Senate Committee Pushes Privatization," Canada Newswire, September 17, 2001

- Writing in the *Edmonton Sun*, Mike Jenkinson "commends" health minister Gary Mar for "thinking outside the box a bit," by considering MSAs, user fees, and making health coverage a taxable benefit. The article claims there are problems with all these ideas, but "still, Mar is on the right track in thinking the patient should be more directly involved." The paper would prefer to privatize the whole system and let people pay premiums, instead of taxes, for their health coverage.

Source: "Good Idea, Gary," *The Edmonton Sun*, September 20, 2001

- The *Vancouver Sun* ran an article about "a (British Columbia) health economist who has spent the last year studying the health care systems in various countries" and concluded Canada should try out the "user-pay concepts employed by Singapore." Economist Cynthia Ramsay looked at the systems of eight countries and concluded Singapore has the lowest mortality rates and the lowest costs of all of them. Ramsay is described as "a big supporter of the medical savings accounts" used in Singapore.

Source: "Singapore Has Health Lessons for Canada," by Pamela Fayerman, *Vancouver Sun*, August 25, 2001

- The *Calgary Herald* comments that, while many Canadians would like to see a greater role for the private sector in health care, they also want more direct federal involvement. Counter to that trend is outgoing Calgary health chairman Jim Dinning, who would prefer to experiment on a local basis, rather than inflicting any particular idea on all 30 million Canadians.

Source: "Try Something New: The Role of Ottawa Must be to Promote, Not Hinder, Health Care Alternatives," *The Calgary Herald*, July 16, 2001

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# Individual Health Insurance: Solution for the New Economy?

**PART 2 IN A TWO-PART SERIES**
**BY MERRILL MATTHEWS JR., PH.D.**

The employer-based health insurance system has worked well in the United States for a number of years. But changes in the workplace and the health care system are making employer-based health insurance an anachronism. U.S. workers increasingly are abandoning the traditional, onsite 9-to-5 job. And rising health care costs are making low-deductible insurance unaffordable.

Are health insurance policies available that can adapt to these changes? Yes, in the individual market for health insurance.

## Benefits of the Individual Market

There are some significant benefits in the individual health insurance market that are not available in the small- and large-group markets.

For example, the individual health insurance market works more like other types of insurance, where individuals purchase and own their policies themselves. When they change jobs, those health insurance policies travel with them.

In the individual market for health insurance, individual consumers can meet personally with an insurance agent, who must cater to the policy owner, not to an employer. Consumers in the individual market comparison-shop; they choose the benefits and coverage they want, need, and can afford from a variety of insurers, plans, deductibles, or co-pays. Or they can choose to enroll in an HMO. Once they decide on a plan and are accepted, the policy belongs to them.

In some states, the individual market for health insurance works very well: Individuals can get good coverage at reasonable prices. Indeed, in many states individual policies are significantly less expensive than group policies—turning on its head the conventional wisdom that if you want affordable heath insurance, you have to be in a group policy.

One reason for this reversal is that some states have tried to minimize the financial impact of the regulations and mandates they impose on the market. For example, a state may mandate that insurers offer specified coverage, such as drug and alcohol abuse counseling, but may not require that they cover that service in every policy.

In addition, good states avoid or limit guaranteed issue provisions, the most destructive mandate to a health insurance market. According to Blue Cross Blue Shield, 13 states have passed some form of guaranteed issue, and 10 of those have also passed community rating, which requires insurers to charge the same price for a policy regardless of a person's health status.

**For more information…**

**WWW** see Matthews' "The Individual Market for Health Insurance: A Solution for the New Economy?" published by the Employment Policies Institute in March 2001. **www.epionline.org**

## Finding Affordable Policies

One way to comparison-shop insurance premiums is to go to **eHealthInsurance.com**, which lets consumers enter a zip code and get a health insurance quote, usually from several different companies and a wide range of plans. For example, a family of three (a male and female adult, age 40, and one child, age 10) looking for a policy with a $2,500 or a $500 deductible might consider the following options *(figures for illustration only, as premiums may fluctuate over time)*:

Denver, Colorado
- $2,500 deductible PPO from United Wisconsin Life/American Medical Security - $178/month
- $500 deductible PPO from Anthem Blue Cross Blue Shield - $293/month

Oakland, California
- $2,500 deductible PPO from Health Net - $218/month
- $500 deductible POS from PacifiCare - $659/month

Indianapolis, Indiana
- $2,500 deductible PPO from Golden Rule Insurance Co. - $112/month
- $500 deductible PPO from Unicare - $239/month

Harrisburg, Pennsylvania
- $2,500 deductible PPO from United Wisconsin Life/American Medical Security - $158/month
- $500 deductible PPO from CeltiCare - $449/month

Chicago, Illinois
- $2,500 deductible PPO from Golden Rule Insurance Co. - $172/month
- $500 deductible PPO from Unicare - $327/month

## Making the Individual Market Work Better

Even though the market for individually purchased health insurance works well in some states, it could work better nationwide. There are two primary actions Congress could take to encourage more coverage with individual policies and reduce the number of uninsured: reform the tax code and eliminate mandates.

Although implementing these reforms will not achieve universal coverage, they would go a long way toward moving the 38 million uninsured into the insured camp, which also would reduce cost shifting. In turn, this change would put less upward pressure on insurance premiums.

In addition, a mechanism needs to be found by which individual policies can be bundled together and sold to a group—providing employers with the benefits of the individual market, but with the cost savings that can come with the group market.

Expanding the individual market for health insurance would expand choice, lower costs, and decrease the number of uninsured. A growing individual market would:

- *Compliment the current shift from defined benefits to defined contributions.* The trend in employee benefits management is for employers to shift from defined benefit plans to defined contribution plans. This trend blends very well with the workplace changes coming about as a result of the New Economy.
  As employers increasingly move to defined contribution benefits, they will likely make health insurance benefits a part of that package—giving employees a set amount of money with which to purchase health insurance, set money aside in Flexible Spending Accounts or Medical Savings Accounts, or a pension plan. Under this scenario, the employees would decide how much to allocate where.
- *Create more consumer choice.* In health care, as in many other realms, people want more choices, not fewer. The retail market and the Internet are making a wide range of goods and services available at reasonable prices that were not available in the past. That demand for more choice has already begun to penetrate the health insurance market. (See "Survey: Americans Want Health Care Choice," *Health Care News*, October 2001.)
  Large- and small-group health coverage has typically offered very little choice. Not so in the individual market. When the market is not hampered by regulatory restraint, consumers can mix and match the various components to design a plan that fits their own needs. Giving more people more choices will raise satisfaction levels, as patients begin to feel they have the health insurance policy of their own choosing, rather than a policy handed to them by someone else.
- *Encourage more low-income people to get health insurance.* A tax credit sufficient to cover most or all of the cost of a basic health insurance policy would encourage millions of people to get basic coverage. As more people moved into the ranks of the insured, that change would increase demand for choices in the health insurance market. But more importantly, it would decrease the number of uninsured.
- *Reduce cost shifting.* Having more people insured would decrease the financial pressure on doctors and hospitals that treat the uninsured, even when they know they may not get paid for their services. Those uncompensated expenses are often shifted to those who do pay their bills, which means insurance often pays more than the true cost of the care. Reducing or eliminating cost shifting would lower the upward pressure on premiums, making them more affordable and leading to even more people being insured.

## Conclusion

While the employer-based health insurance system can and will evolve, it is not clear that system is flexible enough to meet the needs of the changing workforce. But the individual market can, and it already provides coverage for millions of American families. The individual market provides the choice and protection consumers want and need … at affordable prices.

*Dr. Merrill Matthews Jr. is a visiting scholar with the Institute for Policy Innovation in Dallas, Texas; policy director for the American Conservative Union; and assistant editor for* Health Care News.

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# Nationalizing Health Care One Slice at a Time

BY RICHARD A. EPSTEIN

The medical privacy provisions of the Health Insurance Portability and Accountability Act of 1996 undermine our ability to get an accurate assessment of the costs and benefits of information disclosure.

HIPAA contains an ostensibly innocuous command that only "relevant" information can be disclosed. But it offers no definition of what information counts as relevant in cases of medical uncertainty.

Let's take a very simple case: Say somebody who has medical records on file at a hospital in Illinois is involved in an automobile accident in Ohio. Which medical records does the Illinois hospital send to Ohio?

Now, if it is my body, I say send the whole file fast. I don't want anything to be left out, because I don't know what the physicians in Ohio will regard as relevant. But somebody in Illinois may say, well, he only broke his arm, so we'll send only the arm-related information. That could take an hour to figure out, and in the interim I'm dead because the Ohio hospital didn't get even that limited information in a timely fashion.

Apparently we're supposed to tolerate this type of mistake in a welfare state, because we understand that the government's motives are benevolent even if the consequences of its actions are unfortunate!

### "Minimum Necessary Disclosure"

Such risks are real. Suppose that I am taking a leg medicine, which means that if you give me a certain arm medicine you're going to harm or kill me. I would rather trust the physician on the spot to look at the entire medical record and figure out what potential interactions to guard against than to have somebody, no matter how able, try to decide at the point of release what information to forward.

I would hate to go into the operating room and hear, "Well, when you were in the emergency room, we didn't think surgery would be likely, so only this information was necessary; now we've got to request an urgent update with more information" . . . subject, perhaps, to the same mischievous relevancy constraints.

Again, time turns out not only to be money but to influence the odds of survival. My own judgment is that anyone who runs the error calculations will quickly lurch to the optimal solution: The emergency room doctor gets everything, but only for restricted uses related to my well-being; he cannot turn around and sell my records to a soap vendor the next day.

That's exactly the way business was done before HIPAA. At that time, nobody used a "minimum necessary disclosure" requirement—precisely because full information is likely to minimize errors in decisions made under conditions of uncertainty. It makes no sense to spend time and effort to shrink the flow of information.

### Expanding Spheres of Influence

A second troubling feature of HIPAA is how it works to extend the sphere of its own influence. The original mandate under HIPAA covered some, but not all, provider operations. What the regulators manage to do is stipulate that any covered entity who provides a medical record to a person or firm—even if that person or firm is not part of the HIPAA umbrella—must require, by contract, that person or firm to observe all the HIPAA requirements. And so mandatory contracts become the weapon of choice to expand government power, when in fact there has been no clear delegation of authority.

There is something deeply troubling about these developments because of their Orwellian use of language. The mantra behind HIPAA's privacy regulations is consent—an honorable theme for those who care about liberty. But in this instance, the rules in fact use the "consent" label to disguise coercion. The key strategy: All individuals are required to give consent, not comprehensively, but for each separate transaction.

What the regulations do is create a system in which each of us is required to exercise, repeatedly and against our own will, this right to permit others to use information about us. But we cannot waive the protections of the act that require individual consent to be given by putting on the Internet a form that says, "Doc, use whatever records you want in the way that you think best, in accordance with the common practice of your institution."

### Salami Health Care

Putting all the pieces together, what is going on here?

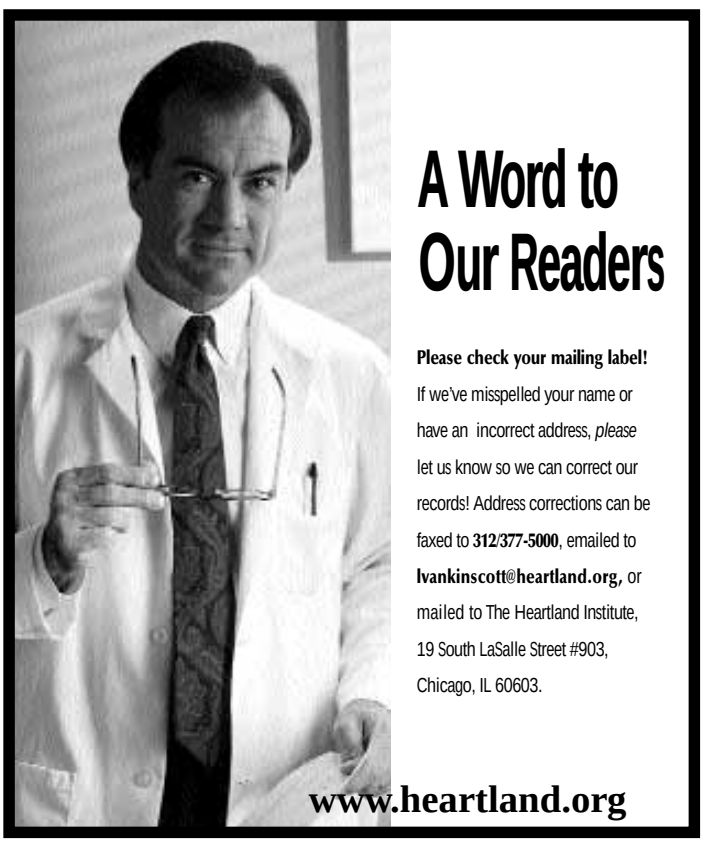
The single largest and most ambitious power grab in the history of American health care was the proposed Clinton Health Security Act, which failed in 1994. Essentially, that bill was an effort to create a massive regulatory apparatus to control, either directly or indirectly, the provision of all private forms of health care.

It failed, so HIPAA continued the search for government control by the salami tactic: Take control of the industry one slice at a time. And here the move to disarm the opposition is to announce that government insists on the various sorts of restrictions to protect against pervasive market failures in the private sector. Once those regulations are imposed, of course, the system will not be able to respond to the challenges it faces without incurring additional costs for few, if any, benefits.

The upshot is that the health system will creak even further. That further decline will in turn justify further forms of regulation, and then, by the time we are done, this hodgepodge system of market-cum-regulation will be deemed unworkable . . . so that the only sensible solution is in fact single-payer nationalized medicine.

Got it?

*Richard A. Epstein is an adjunct scholar at the Cato Institute and professor at the University of Chicago Law School and Hoover Institution. This essay is excerpted from his luncheon address on July 31 to a day-long Cato conference, "Making a Federal Case Out of Health Care."*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# Is Maryland Following in TennCare's Wake?

## *Old Line State's Medicaid program awash in red ink*

BY CONRAD F. MEIER

Soaring administrative costs, rich benefits, ineligible enrollees, general health care inflation, and underfunding have combined to create a $150 million pool of red ink around HealthChoice, Maryland's Medicaid program. Substantial cutbacks in state-run medical care for 500,000 state residents are anticipated.

The same scenario has crippled TennCare, the Tennessee Medicaid program. In late September, Tennessee Governor Don Sundquist unveiled plans to completely overhaul the program. (See "High-Risk HIP Will Return to Tennessee," *Health Care News*, October 2001).

Maryland's funding shortfall, detailed in a legislative report released in October, is straining a range of state-run health programs. The troubles coincide with financial problems in the state's mental health system, which analysts agree is heading toward a major crisis.

State Senator Christopher Van Hollen Jr. (D-Montgomery), vice chairman of the Senate budget committee, told the *Washington Post*, "We saw this as a major concern last year, and this year we're looking at something even more serious. It's fair to say the situation is dire."

### Underestimates Cause Underfunding

A convergence of factors is being blamed for the state's Medicaid debt. The money crunch was to be the subject of a report originally scheduled for release in September.

According to David Romans, a legislative budget analyst, the report finds Governor Parris N. Glendening (D) underestimated both the number of people who would enroll in the state-run HealthChoice program and the amount those patients would spend for treatment and medication.

Calls to Glendening's media office seeking comments for this story were not returned. One question *Health Care News* would like to ask: How much of the state's tobacco settlement had been directed to health care issues, and how much was instead re-directed to other budget items?

Glendening has not yet signaled how he would resolve the debt, but lawmakers said it will not be an easy fix. "We don't have a lot of money just laying around," said House Speaker Casper R. Taylor Jr. (D-Allegany). Several states, including Tennessee and its beleaguered TennCare program, are experiencing shortfalls in Medicaid funding.

### Unintended Consequences

As one of the architects of Maryland's public health care system, Taylor has favored far-reaching coverage. He helped create a system designed to direct impoverished Marylanders into special managed care programs. Those programs are then reimbursed at capitated rates set by the state, with a matching contribution from the federal government.

A key question is whether the state will be forced to make cuts that would directly affect medical care. While some believe painful cuts are inevitable, the Glendening administration has argued targeted cuts can gradually pay off the debt without depriving patients. Taylor, by contrast, thinks the state has only two choices: Either find more money for health care programs, or make painful program cuts.

### Low-Balling the Numbers

The governor included only enough money in the current budget to cover 428,000 enrollees. The actual number is now closer to 458,000. In a downturning economy, expectations are for further increases in demand.

As the cost of health services has increased, so has the level of complaints from managed care companies, who claim the reimbursement payments they receive from the state are well below actual costs. Delegate John A. Hurson (D-Montgomery) worries the five-year-old program is about to collapse because it has not been adequately funded.

After holding a hearing for the managed care companies last week, Hurson and Senator Thomas L. Bromwell (D-Baltimore County) wrote the governor, urging him to increase reimbursement rates or risk seeing companies withdraw from the program. If enough plans drop out, Hurson said, it could mean "chaos" for Medicaid patients, who would have to find doctors willing to accept direct payment from the state, often at very low rates.

The state's reimbursement schedules are so outdated that a cardiac surgeon would receive only $80 for a heart catheterization. A review of heart disease-related costs suggests no doctor on the East Coast would take $80 for that procedure. According to the American College of Cardiology, the average cost for treating heart disease is a little over $4,000.

### Mental Health and Long-Term Care

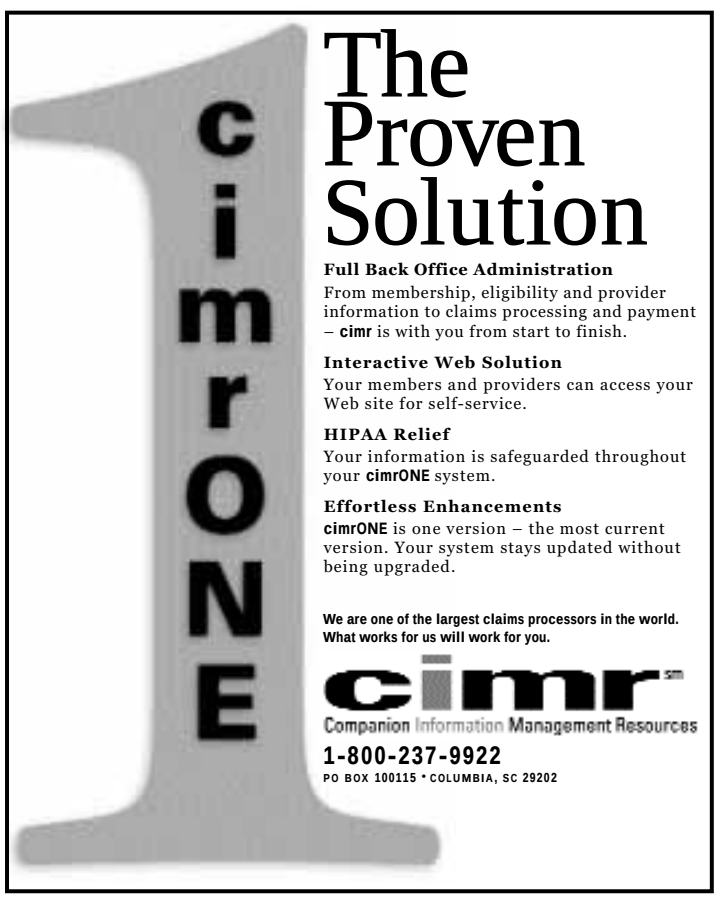
In Montgomery County, the largest mental health provider, CPC Health Inc., recently went bankrupt and closed its 91-year-old Chestnut Lodge Hospital. Other clinics are now straining to meet their payrolls. Clinic operators told county officials last week an emergency infusion of $870,000 is needed to keep facilities open.

Baltimore County health officials met with owners of a dozen area treatment centers last week to plea for help in treating 1,600 patients who will be abandoned by Granite House Inc. The financially strapped company lost money on most patients and will shut down two of its largest clinics.

> **"We saw this as a major concern last year, and this year we're looking at something even more serious. It's fair to say the situation is dire."**
>
> **HON. CHRISTOPHER VAN HOLLEN JR.**
> **STATE SENATOR (D-MONTGOMERY)**

Legislative analysts estimate mental health facilities are carrying more than $30 million in debt, despite a last-minute $30 million infusion of cash in the spring.

Similar worries recently struck the state's nursing homes, which have cost the state at least $33 million more than was budgeted. Fifty of the state's 250 nursing care facilities are in bankruptcy proceedings.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## *Huckabee Resists Clinton Mandate*

BY CONRAD F. MEIER

Arkansas Governor Mike Huckabee (R) is considering a Medicaid mandate from the former Clinton administration moot, since the Bush administration has not attempted to enforce it.

In July 2000, the Health Care Financing Administration (now the Center for Medicare and Medicaid Services, or CMS) attempted to force the state to enroll all eligible children in ARKids A, the state's traditional Medicaid program. The mandate would have prevented the state from allowing parents the option of enrolling their children in ARKids B, a Medicaid waiver program that covers children with higher incomes.

> **"Our thought is the administration that sent that letter is gone . . . and we haven't had a moment of trouble from the Bush administration."**
>
> **HON. MIKE HUCKABEE**
> **GOVERNOR, ARKANSAS**

The B waiver program requires a "small" copayment and offers fewer services than the traditional Medicaid program. Proponents of the B plan say free coverage under the traditional A program carries a "stigma" that not all families want to subject themselves to.

According to the *Arkansas Democrat-Gazette*, Huckabee has wanted to allow parents of Medicaid-eligible children to choose between the two programs. Huckabee added that some "prideful" parents would prefer to enroll their children in ARKids B because they "want to contribute to their children's health coverage" through the copayments.

A Kaiser Daily Health Policy Report noted, "Despite the Clinton administration's order to place all Medicaid-eligible children into ARKids A, Huckabee resisted 'in the hopes that Bush would be elected.'" After daring the Clinton administration to pull his state's federal funding for not following the order, Huckabee said he thought the Bush administration, with Tommy Thompson as HHS secretary, would allow Arkansas to manage the programs as it saw fit.

Referring to the Clinton directive, Huckabee said, "Our thought is the administration that sent that letter is gone. That administration is gone, and we haven't had a moment of trouble from the Bush administration." In February, Arkansas filed a formal waiver request, which is still pending, allowing parents to choose between the two programs.

Peter Ashkenaz, a spokesperson for CMS, said in October the agency was "waiting for a response" from Arkansas before making a decision on the waiver.

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TENNESSEE continued from page 1

BlueCross. "We need to find a way to give those who participate in TennCare an advantage in the marketplace, or get those who don't a slight disadvantage, perhaps a higher premium tax to cover the burden they're shifting," he said.

Play or pay has long been advocated by BlueCross BlueShield of Tennessee, an obvious beneficiary of forced participation in TennCare. The insurer is the largest managed care organization in TennCare, covering 575,000 of the program's 1.3 million enrollees.

### Bumper Sticker Mentality

Dave Goetz, executive vice president of the Tennessee Association of Business, sees things differently. He told reporters, "The problem is, businesses are not (failing to offer) health care because they're bad people. They're not offering health care because they can't afford it."

He added, "The idea that somehow all you have to do is pass a law and you will force companies to do something is really nonsensical. What you will force them to do is leave Tennessee." Over 90 percent of the businesses in his organization provide health insurance for their workers.

To some observers, the effect play or pay legislation could have on small businesses appears obvious. State Senator David Fowler (R-Signal Mountain) told the *Chattanooga Times and Free Press*, the proposal could "stifle entrepreneurship" and introduce "bankrupting costs. The businesses that don't offer health care now are those that are the most marginal. If they could offer health care and attract better employees, they'd be doing it."

> **"What they're trying to do is put a different saddle on a dead horse and bring it back to life."**
>
> **HON. DAVID FOWLER**
> **STATE SENATOR**

State Senate Speaker Pro Tem Bob Rochelle (D-Lebanon) is skeptical as well. "Pay or play is a nice bumper-sticker solution," he said, "[and] nobody's been able to come up with the details of a plan."

"The goal is to try to have an impact on businesses that don't supply health insurance," Rochelle explained. "Well, an inordinate number of those are small businesses. When you force additional expenses on them you have impacts, too. As for the larger companies that don't provide health insurance, we haven't had that many pointed out to us."

### Gaming TennCare

Like Governor Sundquist, however, Senator Rochelle said the state should try to lure insurers into TennCare with incentives, rather than punish them for their lack of participation. "We have to find a way to make it financially advantageous for these companies to participate in TennCare. We'd rather have them participating as strong MCOs, than be forced to have to tax them," he said.

Representative Gene Caldwell (D), chair of the Joint TennCare Oversight Committee, said, "We have anecdotal evidence that a lot of small companies have dropped insurance so their employees can get on TennCare. We don't think that's right." He added, "The play or pay plan is the way the state might push business into participating. Whether it will pass or not, I don't know."

Last year, Caldwell noted, a play or pay bill "died quietly" in a legislative committee.

TennCare's Tighe said the program "should be the last resort, not the first," for most Tennessee residents. "If you're a businessman who offers health insurance to your employees, you're contributing," Tighe said. "If you don't and you are benefiting because TennCare is covering your workers, you ought to be contributing."

The current Medicaid waiver for TennCare, a $5.3 billion program, will expire at the end of this year. The Bush administration has promised continued funding from the federal Center for Medicare and Medicaid Services (formerly HCFA) should the state's new waiver request not be ready by the deadline. The TennCare reform proposal includes a top-to-bottom restructuring of the program's organization, administration, and governance. It also calls for a complete reworking of its benefits structure.

Senator Fowler summed up the reform plan this way: "What they're trying to do is put a different saddle on a dead horse and bring it back to life."

# *Medicare Plans May Get Cash "Infusion" From Feds*

**BY CONRAD F. MEIER**

CongressDaily reports Thomas Scully, administrator for the Center for Medicare and Medicaid Services (CMS), predicted on October 15 a "better than even chance" lawmakers would provide Medicare managed care plans with an additional "infusion of cash" before legislators adjourn for the year.

At the same time, Scully, speaking to the American Association of Health Plans, "backed away from earlier predictions" Congress might address "in a major way" a number of concerns prompting health plans to withdraw from the troubled Medicare+Choice program.

Scully said the FY 2002 budget "situation" and the "crush of other business" would make reforms a "tough call" for lawmakers. He reportedly said the administration would "continue to push" the pharmacy discount card program President Bush unveiled in July, despite a September court ruling that has blocked the program temporarily.

"We are very, very committed to getting this program in place," Scully said, adding, "Getting seniors buying drugs in bulk to get discounts is the one common denominator" among Democrats and Republicans.

### Closing a Loophole

CongressDaily also reported Scully's plan to issue a regulation that will "further restrict" the Medicaid "upper payment limit."

A loophole in that limit currently allows states to pay city- or county-owned health care facilities more than the actual cost of health services, thereby qualifying the state for additional federal matching funds from CMS. Some states pay the facilities a small fee for their participation in the Medicaid program, but the facilities are not required to spend that money on health care for low-income patients.

"It's a scam," Scully said. "We just have to draw the line. We can't let every state come in and refinance their entire state government through the Medicaid program."

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# State Legislative Update

## A monthly review of state legislative activity

**COMPILED AND EDITED BY CONRAD F. MEIER**

CONNECTICUT

Governor John Rowland (R) gave the state's not-for-profit hospitals a strong dose of taxpayer money. The assistance package repeals the hospital sales tax, for an annual savings of $111 million, and sends $50 million into non-profit hospital bank accounts.

While most hospitals in the state seem to be breathing a little easier now, health care administrators remain concerned about low reimbursements from HMOs and government, along with rising costs for their own insurance, fuel, and employee health plans.

MARYLAND

A new legislative report has found that the state's Medicaid program, HealthChoice, is $150 million in debt, which could "force" lawmakers to reduce benefits. (See story page 6.)

MASSACHUSETTS

Citing rising drug costs, Massachusetts will become the latest state to require Medicaid beneficiaries to use generic drugs when available, a move drug industry executives say may be the strictest program yet.

Starting November 28, the roughly 860,000 beneficiaries in the state's traditional Medicaid program will have to use generic medications in all available cases except when "medical necessity" is demonstrated and doctors obtain prior approval from the state. The 40,000 enrollees in Medicaid managed care programs will remain in their HMO policies.

The state currently requires pharmacists to prescribe generic medications to Medicaid beneficiaries unless doctors request brand-name medications. The changes could save the state $10 million in the first year.

MINNESOTA

Governor Jesse Ventura (REF) says thousands of striking workers are "saving the state money." State workers went on strike demanding millions of dollars more than the state can afford.

Union leaders say the first state employees' strike in 20 years was "forced" upon them by a state health insurance proposal that could reduce some employees' take-home pay by 25 percent. Julien Carter, the state's commissioner of employee relations, says the state and leaders of the Minnesota Association of Professional Employees (MAPE) are "far apart." He labeled the union's expectations "unreasonable."

MISSISSIPPI

Administrators of Mississippi's Medicaid program have sought an additional $446 million in the 2002 budget.

State Division of Medicaid Director Rica Lewis-Payton told a recent state Joint Legislative Budget Committee hearing lawmakers should budget additional state funds to take full advantage of federal matching funds. The federal government provides $4 for each dollar the state allocates for the program.

During the hearing, state lawmakers asked questions about a $124.6 million deficit in the current state Medicaid program. According to Lewis-Payton, state Medicaid enrollment has increased, while the federal match rate has decreased. She also said state lawmakers required Medicaid to provide additional services but didn't set aside money to pay for them.

MISSOURI

Governor Bob Holden (D) got what he asked for … and maybe more. The state has scrapped a previous prescription plan—which ballooned to over $85 million a year on a $20 million projection.

According to the governor's prescription task force, the new plan will cost $50 million in the first year, and roughly $80 million the second. But an independent actuary hired by the legislature projected a price tag of $99.6 million. The discrepancy arises from differing projections of how many residents will actually use the plan. Holden says he hopes to pay for the plan with funds from the general revenue and from the state's tobacco settlement.

NEW YORK

New York state legislators have decided to allow all legal immigrants to receive health benefits under Family Health Plus, a new program intended to provide health insurance for the working poor who have incomes too high to qualify for Medicaid. To be eligible for the program, a family of four must have an income that does not exceed $23,475 per year, slightly more than the federal poverty level.

Covering legal immigrants is expected to cost the state $10 million. A total of roughly 600,000 uninsured individuals, immigrant and native, will be covered by the $1.1 billion effort over the next three years. Previously, state officials had been noncommittal about whether some immigrants would be eligible for the program, noting federal welfare laws bar legal immigrants who arrived in the country after 1996 from receiving certain public benefits.

State Deputy Health Commissioner Robert Hinckley, who announced the decision to extend Family Health Plus benefits to legal immigrants, said it is unclear when the coverage for immigrants will begin because State Comptroller H. Carl McCall has not yet approved the health department's contracts with private insurers. The *New York Times* reported the comptroller's office said it could not approve the contracts until "crucial questions," specifically concerning immigrant coverage, were answered.

TENNESSEE

Responding to critics who have said plans to revamp TennCare, Tennessee's Medicaid managed care program, will never be approved by the federal government, Governor Don Sundquist (R) said he believes the government will "be receptive" to the revamp proposal.

"TennCare is an experiment and it's one that is ever-evolving. I believe our waiver will be approved," said Sundquist.

TennCare would be split into three insurance pools. The proposal also would cut from the current TennCare program about 180,000 beneficiaries who are Medicaid-ineligible, a move that would save the state $150 million. (See "High-Risk HIP Will Return to Tennessee," *Health Care News*, October 2001.)

WASHINGTON

To control soaring prescription drug costs, Washington's Medicaid program plans to push physicians to prescribe more generics by limiting beneficiaries to four brand-name drugs per month. The Medicaid program's drug costs have almost doubled over the past three years, now reaching $500 million a year.

Under the "Therapeutic Consultation Service" program, if a patient attempted to fill a fifth brand-name prescription in a month, the pharmacist would contact the physician, who would then have to contact a pharmacist hired by the state for approval. The state-approved pharmacist would examine the patient's current prescriptions to "prevent duplications and dangerous interactions."

According to Siri Childs, a pharmacy research specialist with the state Department of Social and Health Services, "Our attempt is not to restrict drugs. It's to make sure patients are getting the right drug." Contraceptives, HIV medications, chemotherapy drugs, antidepressants, and antipsychotics would be exempt from the four-drug limit. The program is slated to begin January 1.

*Sources: The Council for Affordable Health Insurance (CAHI) and its member companies provided information for this State Legislative Update. Contact CAHI at mail@cahi.org, Additional material was provided by The National Association of Health Underwriters (NAHU) http://nahu.org/government, http://bizjournals.com, http://stateline.org, and Nexis/Lexis research.*

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# How Britain Rations Health Care

## *And you thought HMOs were bad . . .*

BY LOGAN ELIA

Currently, a Task Force is meeting in Arizona with the goal of expanding the Arizona Health Care Cost Containment System (AHCCCS), the state's health care plan for low-income residents.

Britain's National Health Service appears to be the model for at least one member of the task force. Rep. Linda Binder told reporters that when she was a child in England, she "never knew growing up what it was to be denied care." Is the British system really a model for Arizona policymakers?

### Free . . . When You Can Get It

The National Health Service is a government-run organization that aims to provide the best possible health care to all citizens of the United Kingdom, free of charge at the time of service. To some extent, the NHS meets its goal. The United Kingdom does have a high standard of care, and medical care is free at the point of purchase. Of course, calling the care "free" requires overlooking the enormous tax burden borne by citizens to pay for this.

Moreover, the laws of market economics do not cease to hold for the health care industry in the UK just because government provides the service. By achieving its first two goals—care that is both high-quality and free when delivered—the NHS has also succeeded in causing demand for care to far outstrip the capacity of the system to supply it.

To accommodate the demand, the NHS has had to ration care. Care may be free of charge at time of service, but that time of service might not come in the same year one might think it should. NHS guidelines currently allow inpatients to wait 18 months for hospital tests or treatment. The waiting list to be admitted to a hospital tops 1 million people, and over 40,000 of those have been on that waiting list for over one year.

NHS patients are expected to wait 26 weeks to see a specialist after they have been referred to that specialist by their general practitioner—whom they also had to wait to see. In January 2001, there were 180,000 people waiting to see consultants. Dr. Liam Fox, former opposition leader on health issues in Parliament, explained that this number essentially represents the number of people waiting to be added to the waiting list for care.

The waiting lists are not likely to get shorter any time soon. A recent poll to which two-thirds of UK doctors responded found that 80 percent of them would consider leaving the health field if the NHS remains as it is.

The official NHS Web site praises a particular hospital at which patients need only wait 18 weeks for treatment of back problems. That hospital had reduced its wait time from 89 weeks. The Web site also lauds hospitals that are beginning to allow patients to schedule appointments to see specialists according to what's convenient for the patient, rather than according to the hospitals' arbitrary choice of appointment times.

> **"NHS patients are expected to wait 26 weeks to see a specialist after they have been referred to that specialist by their general practitioner—whom they also had to wait to see."**

Even in Sweden—that paradigm of socialist utopia—residents outside of Stockholm wait up to two years for hip surgery.

On the bright side, all of this waiting *is* free of charge . . . even at the time of *disservice*.

### Quality Can't Compare

In the United States, over half of all patients receiving arthritis medication are receiving the newest and highest-quality pharmaceuticals. In Britain, only 15 percent of arthritis patients can claim that privilege.

Restricted access to high-quality pharmaceuticals is a problem that plagues not only Britain's single-payer medical plan, but health care in other countries as well. Like their British counterparts, only 15 percent of German arthritis patients get the latest medications. From 1995 to 1997, pharmacies in Portugal, Italy, and Greece failed to carry over half of the new medications surveyed. Pharmacies in Belgium, France, and the Netherlands lacked over one-third.

These statistics come from countries that have had years to perfect their socialized medicine programs. However, even the United States can be a source of statistics on socialized medicine. Medicare denies more claims for medical necessity than the private sector does.

What evidence is there that expanding Arizona's state government health programs will lead to results any better than these? Universal health care has a long history, and that history teaches only one lesson: It will not work.

*Logan Elia is a research assistant at the Phoenix, Arizona-based Goldwater Institute for Public Policy.*

DOCTORS continued from page 1

- Affordable "bare-bones" health insurance, including the repeal of state insurance mandates currently requiring a variety of nonessential benefits and providers of other services.
- Refundable tax credits for people buying individual insurance policies.
- Elimination of the federal cap on the number of Medical Savings Accounts, which are given preferential tax treatment.

The WSMA also declared it would press the state to increase Medicaid payments to physicians by making Medicaid's reimbursement rates as high as Medicare's. And the association would support legislation eliminating the business-and-occupation tax on payments physicians receive from Medicaid, Medicare, and the state's Basic Health Plan.

According to news sources, the WSMA's new president, Dr. Sam Cullison, stated, "We remain committed to access to affordable insurance for all, but our focus must be on saving medical practices from further deterioration."

### The Problem Is Money

Underlying all the issues is money. Physicians believe the legislature budgets too little for Medicaid and the Basic Health Plan, which then pay doctors too little to cover the costs of their services.

Most association physicians question whether they would fare better under a single-payer system. Many suspect they would not. If the government under-funds its health programs now, they worry, how can it be expected to do any better under a single-payer for all health services?

"Many of the difficulties we face today come from the government's penchant to over-promise and under-fund its programs," observed Dr. Nancy Auer, immediate past president of the WSMA, in a report to the association's board. Her observation is supported by an independent report, "Health Care Financing and Delivery System Options: An Impartial Evaluation," conducted last year for the association by respected Seattle analyst Lance Heineccius.

In weighing the advantages and disadvantages of a state single-payer system, Heineccius says under such a system, payments to physicians and other providers of health services "would likely decline due to limited funds available to the state for the program."

Over time, Heineccius predicted, the government would more than likely reduce payments to providers to balance the state budget, rather than increase taxes and increase patients' financial responsibility. The ultimate cost-control would be the rationing of many health care services.

### Universal Infrastructure Exists

The debate over what to do about health care financing and health care delivery has been going on for years. Last year, the WSMA created a task force on health care financing reform, guided in part by the association's goal of universal insurance coverage for all Washington residents.

Auer recently reported to the association's board the seven-physician task force decided "much of the policy and legislatively created infrastructure to get universal access to affordable health insurance and to services is already in existence."

That infrastructure includes Medicare, Medicaid, the Basic Health Plan (for the state's working poor), the Medically Indigent Program, employer-sponsored coverage for employees, and the revived individual insurance market.

### What Should Be Covered?

One of the key problems with the existing system, according to Auer and the task force, is everyone wants everything to be covered by insurance. As a result, insurance products are burdened with regulatory demands in the form of unfunded benefit mandates. "Health care does not operate in a vacuum," agreed Joseph Bast, president of the Chicago-based Heartland Institute. "When consumer demand is replaced with regulatory demand, the consumer loses."

"The business community will testify that the lack of affordability of many of the products in the marketplace is a leading reason for the lack of coverage for many employees," Auer noted.

At a minimum, the task force recommended coverage to include:

- primary care
- specialty care
- physician and mental health services
- inpatient hospital services
- prenatal and maternity services
- home health and hospice services
- prescription drugs
- durable medical equipment
- diagnostic imaging and laboratory services.

### Senseless Mandates

The task force's package excludes many state-mandated health care services. For instance, Auer said the task force questioned "the value of financing massage therapy as a benefit in an insured product."

"What is the value to society when in 2000, Regence BlueShield paid out more for massage therapy than for oncology services?" Auer asked. "To the task force, this simply does not make sense."

> **"Many of the difficulties we face today come from the government's penchant to over-promise and under-fund its programs."**
>
> **DR. NANCY AUER**
> **IMMEDIATE PAST PRESIDENT**
> **WASHINGTON STATE MEDICAL ASSOCIATION**

The debate over whether to reform or replace Washington's health care system is certain to continue. The Health Care 2000 group will likely press on with its agenda, despite two failed attempts last year to collect enough signatures to qualify a single-payer initiative for presentation to the voters and to the legislature.

During the 2001 legislative session, the group's initiative was introduced as Senate Bill 5768. The bill failed, but Independent Business Association director Gary Smith recently cautioned his members: "This concept is much more than just an idea. It is probably less than 10 votes away from becoming law in Washington state."

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# Hospital Costs Drive Medical Inflation

## *Study: Prescription drugs not to blame*

BY CONRAD F. MEIER

Pharmaceutical companies, it seems, are not the bad guys after all.

"Tracking Health Care Costs," a new study published by the journal *Health Affairs*, puts things into proper perspective. According to the report, hospital costs outpaced prescription drugs as the biggest factor fueling health care spending in 2000.

The study was conducted by the Center for Studying Health System Change (HSC), a Washington-based policy research organization funded solely by the Robert Wood Johnson Foundation.

According to the study, health care costs increased 7.2 percent in 2000, the largest jump in a decade. Inpatient and outpatient hospital care expenses accounted for 47 percent of the increase.

Preliminary data for 2001 suggest spending in three key areas—inpatient care, outpatient care, and prescription drugs—continues to climb, while spending for physician services has remained flat.

### Insurance Premiums Increase

Rising health care costs in 2000 helped fuel premium increases for employer-sponsored coverage that averaged 11 percent in 2001, according to the study. HSC reasons consumer demand for broad networks of hospitals and physicians and the easing of restrictions by health plans, coupled with hospital consolidation and a reduction in excess capacity, have increased the bargaining clout of some hospitals vis-a-vis health plans.

"Hospital spending is back with a vengeance, and the likely causes are the retreat from tightly managed care, which has increased demand for hospital services, and rising labor costs," said Paul B. Ginsburg, a study co-author and president of HSC, in a press release announcing the findings.

"The volatile combination of rising costs, increasing premiums, and a slowing economy have set the stage for consumers to pay more for care and an increase in the number of uninsured Americans," Ginsburg said.

Among the study's specific findings:

- Spending for outpatient care increased 11.2 percent in 2000, up from an 8.9 percent increase in 1999.
- Spending for inpatient care increased 2.8 percent in 2000, up from a 1.6 percent increase in 1999.
- Spending for prescription drugs increased 14.5 percent in 2000, down from 18.4 percent in 1999.
- Spending increases for physician services slowed to 4.8 percent in 2000, compared with a 5.8 percent increase in 1999.

### Demand-Driven Increases?

The hospital industry says rising costs simply reflect rising demand. According to a news report in *USA Today*, Carmela Coyle of the American Hospital Association explained, "The driving factor is Americans are using more hospital services."

But health insurance companies say hospitals negotiating for money, not simply consumer demand, fueled the increases. In a statement to the press responding to the study, Karen Ignani, of the American Association of Health Plans, noted, "Our member plans are experiencing requests from providers for substantial increases in reimbursement."

**For more information…**

**WWW** "Tracking Health Care Costs: Hospitals Surpass Drugs as Key Cost Driver," is available on the Internet in both HTML and Adobe Acrobat's PDF file format. Point your Web browser to **http://www.healthaffairs.org/Strunk_Web_Excl_92601.htm** or **http://www.healthaffairs.org/2005Strunk.pdf**, respectively.

## *PhRMA Responds to Study*

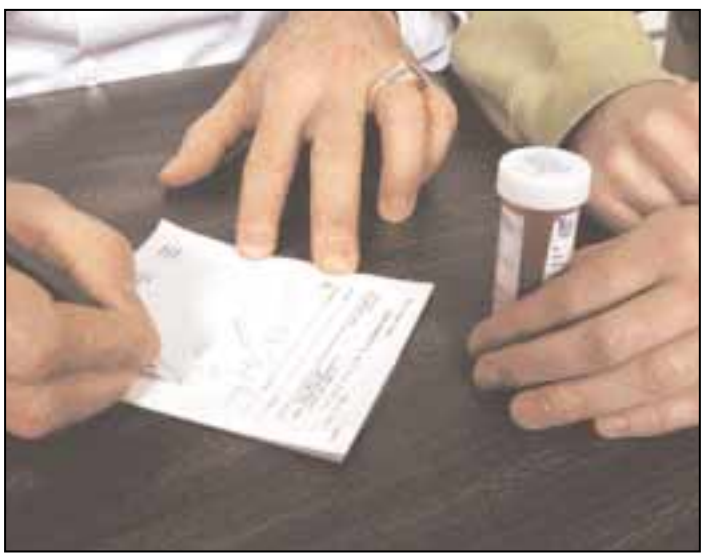
*Alan F. Holmer is president of PhRMA. He issued this statement in response to a new study by the Center for Studying Health System Change.*

The [Center for Studying Health System Change] study found that, while hospital care fueled the largest portion of last year's spending on health, total spending on prescription medicines also increased.

We believe pharmaceutical expenditures are increasing because innovative medicines save lives, improve the quality of life, keep people out of the hospital, and get them back to work—and to their families—sooner. Simply put, there is no comparison between what patients and doctors achieve with today's medicines as compared to yesterday's.

Important research published…in the journal *Health Affairs* documented the value of innovative medicines to patients and the health care system. This study, by Columbia University economist Frank R. Lichtenberg, Ph.D., found that people who take newer prescription drugs were less likely to die or lose work time, spent fewer days in the hospital, and spent less on other health care services.

According to Lichtenberg, the cost of newer drugs was offset by an estimated three-fold reduction in non-drug health care spending. It's also important to remember that outpatient prescription medicines, despite their ability to improve lives and reduce other health care spending, account for only 8 cents out of every health care dollar.



# Vermont Senator Joins Rx Advocacy Group

## *Latest appointment is second lobbying stint for Windsor County liberal*

BY CONRAD F. MEIER

State Senator Cheryl Rivers (D-Windsor), considered one of the most liberal members of the Vermont Senate, has left her seat to take a job with a lobbying group that advocates government control of prescription drug prices.

The chairwoman of the powerful Senate Finance Committee, Rivers has represented Windsor County for 11 years. She was first elected to the Senate after serving as a lobbyist for the Vermont Low-Income Advocacy Council.

Rivers announced her resignation at a State House press conference. She will become the first executive director of the Northeast Legislative Association of Prescription Drug Prices (NLAPDP).

Her new boss is a familiar face. Senator Peter Shumlin (D-Windham), president pro tem of the Senate, is also president of the Northeast Legislative Association. Sources said Rivers had interviewed, was offered, and accepted the job in Boston.

Rivers' husband, Richard, said she was unavailable for comment because she was getting ready to go to the Fryeburg Fair in Maine. Rivers raises and trains Morgan horses. Shumlin couldn't be reached for comment either.

> **"[Rivers'] new boss is a familiar face. Senator Peter Shumlin (D-Windham), president pro tem of the Senate, is also president of the Northeast Legislative Association."**

### Association Seeks Price Controls

The NLAPDP was formed several years ago by the six New England states, plus New York and Pennsylvania, in an effort to find ways to lower prescription drug prices charged by pharmaceutical companies.

Rivers' drug pricing reform bill failed in the waning hours of the 2000 Vermont legislative session in a committee of conference. But a substitute plan supported by Governor Howard Dean was approved, then ruled unconstitutional earlier this year by a federal appeals court.

Rivers has been a strong liberal voice in Montpelier for the past decade. However, the Senate has tilted in a more conservative direction in recent years, and the liberal agenda propounded by Rivers and others has been thwarted by the drift and by the House shift to Republican control in the last election.

Rivers' departure leaves a key Finance Committee post vacant. Rep. Ann Seibert (D-Norwich) and former Rep. Matt Dunne (D-Hartland) have been mentioned as possible replacements. At press time, no Republican names had been mentioned.

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# GlaxoSmithKline Offers National Rx Discounts

BY CONRAD F. MEIER

GlaxoSmithKline (GSK) announced the creation of a new discount program allowing low-income Medicare beneficiaries who lack drug coverage to purchase most of the company's medications at discounts of at least 25 percent.

Under the firm's Orange Card program, which will go into effect January 1, all Medicare beneficiaries with annual incomes at or below 300 percent of the federal poverty level ($26,000 for an individual or $35,000 for a couple) will receive discounts on all GSK medications sold outside hospitals.

Among GSK's most notable drugs are Avandia for diabetes, Paxil for depression, and Flovent for asthma. The company said 11 million people could qualify for the program. Participants would pay nothing for the orange-colored ID card and would show it at most pharmacies to receive the discounts.

> **"[GlaxoSmithKline] will provide a 25 percent discount on the wholesale price of the medication; depending on pharmacy pricing, consumers will receive 25 percent to 40 percent discounts on what they would pay otherwise."**

### Save 25 Percent or More

According to the *Philadelphia Inquirer*, David Stout, GSK's president of U.S. pharmaceutical operations, said the company will provide a 25 percent discount on the wholesale price of the medication; depending on pharmacy pricing, consumers will receive 25 percent to 40 percent discounts on what they would pay otherwise. GSK said it is also negotiating with pharmacies to provide an additional discount.

The *Wall Street Journal* reported the program will be administered by pharmacy-benefit manager Express Scripts Inc. Starting November 1, those eligible for the Orange Card program can pick up an application in their doctor's office or call the GSK Orange Card information line at 888/672-6436. Applicants will be required to provide their Medicare beneficiary number and their previous year's federal income-tax return.

### Closing the Medicaid Gap

GSK officials said they were launching the program to assist seniors who cannot afford prescription drug coverage. GSK CEO Jean Pierre Garnier told the *New York Times* the program would serve as a stopgap until Congress passes a comprehensive Medicare drug benefit. "It is a shame some patients can't get the full benefits of our drugs for economic reasons. We are trying to close the gap," he said.

The *New York Times* noted the discount program may also give GSK a competitive advantage over other pharmaceutical companies that market similar drugs. However, many drug companies who are members of the Pharmaceutical Research and Manufacturers Association (PhRMA) already offer free prescription medications to qualified citizens. (See "My Turn: Stop Demonizing the Good Guys," page 18.)

### Bush Administration Support

GSK's announcement follows an attempt by the Bush administration earlier this year to launch a drug discount card program. Under the Bush plan, pharmacy benefit managers would negotiate discounts with drug manufacturers and pharmacies, then sell discount cards to Medicare beneficiaries for up to $25. The cards would allow holders to purchase pharmaceuticals at a 15 to 20 percent discount.

The Bush proposal, however, was blocked by a federal judge in September after pharmacy groups said they would bear the burden of the discounts. (See "Rx Discount Plan Stalled by Judge," *Health Care News*, October 2001.) The judge issued a temporary injunction, ruling the administration may have lacked the authority to implement the plan without congressional approval.

According to a recent Kaiser Health Policy Report, Health and Human Services (HHS) spokesperson Bill Pierce said the administration "is not endorsing" GSK's plan for seniors. "Obviously, they are doing something like the government wanted to do before the lawsuit."

HHS Secretary Tommy Thompson appeared with GSK officials at an October 3 news conference in Washington to announce the launch of the program.

**Under GlaxoSmithKline's new Orange Card program, low-income Medicare beneficiaries will get prescription drug discounts of 25 percent or more.**
Photo: PR Newswire

# Subsidizing Prescription Drugs: An Ill-Advised Path

BY RAYMOND J. KEATING

While federal officials ponder how to create a new federal entitlement for prescription drugs, many states already have ventured down this ill-advised path.

An article in *The New York Times* on April 23 explained that 26 states were in one way or another subsidizing prescription drug coverage.

The *Times* went on to highlight the various types of programs being offered. For example, some states "use state money to pay part of the cost of each prescription." Others place limits on the prices pharmacies can charge elderly patients; others received permission to use Medicaid programs for drug discounts to people who do not qualify for Medicaid; and others used their Medicaid purchasing clout to force discounts from manufacturers.

If government is going to foolishly venture down the path of subsidizing prescription drugs, then having the various states figure out how to do it probably would inflict the least damage. That is, compared to a federal program, such as expanding Medicare with a prescription drug program, as almost every federal elected official wants to do these days.

### Damage Will Be Done

But make no mistake, no matter which level of government gets involved, damage will be done.

Remember what happens when government picks up more and more of the health care bill. As an ever-greater share of spending is funded by a third-party payer, the health care consumer and provider have fewer incentives to be concerned about costs. Demand is pushed higher, along with prices. And since there are no real incentives to control costs in government, matters only grow worse when government is the third party picking up the tab. Taxpayer costs skyrocket.

Once government starts picking up increasing shares of the prescription drug bill in this nation, rationing and price controls will be inevitable. It will only be a question of when, not if.

Rationing simply means the government will dictate which drugs individuals can have access to, and which ones they cannot. Health care decision-making is placed in the hands of government bureaucrats and politicians.

Meanwhile, price controls result in fewer drug innovations, improvements, and discoveries. If the government resorts to price controls, then fewer resources would be available for investing in new treatments. Indeed, the incentives to undertake the very risky and costly enterprise of researching, testing, and bringing new and improved drugs to the marketplace would be destroyed.

**For more information…**

WWW For a copy of "Medical Savings Accounts: The Necessary Centerpiece of Health Care Reform," released by the Small Business Survival Committee in April 2001, visit the group's Web site at **www.sbsc.org** or call 202/785-0238.

### Deregulate and Cut Taxes Instead

If federal and state government officials are truly concerned about access to affordable, life-enhancing, life-saving drugs, they should not be looking to establish government subsidies that will inevitably lead to rationing and price controls.

Instead, they should be deregulating and cutting taxes to reduce the costs imposed on insurers, drug makers, medical device manufacturers, and other health care providers.

And perhaps most important, tax-free medical savings accounts (MSAs) should be made available to all health care consumers, including Medicare and Medicaid recipients. MSAs tied to traditional catastrophic insurance allow consumers to make their own medical decisions; resolve third-party payer woes; allow savings to build up; cover prescription drugs; and protect people against the costs of catastrophic illness.

The prevailing thinking in political circles is to increase subsidies for prescription drugs. In reality, though, what we need is more choice in the marketplace. Competition works; government doesn't.

*Raymond J. Keating is chief economist for the Small Business Survival Committee and coauthor of* U.S. by the Numbers: Figuring What's Left, Right, and Wrong With America State by State *(Capital Books, 2000). His email address is rkeat614@aol.com.*

**STATES THAT SUBSIDIZE PRESCRIPTION DRUGS**

| | |
|---|---|
| California | Missouri |
| Connecticut | Nevada |
| Delaware | New Hampshire |
| Florida | New Jersey |
| Illinois | New York |
| Indiana | North Carolina |
| Iowa | Pennsylvania |
| Kansas | Rhode Island |
| Maine | South Carolina |
| Maryland | Vermont |
| Massachusetts | Washington |
| Michigan | West Virginia |
| Minnesota | Wyoming |

*Source: New York Times*, April 23, 2001

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# Helping Laid-Off Workers Keep Health Insurance

BY GREG SCANDLEN

Congress has before it several bills to help newly laid-off workers from the airlines and other industries affected by the terrorist attacks on America. President George W. Bush has proposed—and members of Congress from both parties have offered bills—helping these workers to retain their health insurance coverage and avoid joining the ranks of the uninsured.

These layoffs are only one indication that the numbers of uninsured are likely to surge in the next few months. Other ominous signs include the growing ranks of unemployed generally, shrinking business sales and profits, and the dramatic increases in health care costs expected in the coming year. Many employers are likely to eliminate more jobs or hire no new workers. Other employers may keep all their workers on the payroll but will be hard-pressed to continue their health care coverage.

**For more information…**

WWW *contact Steven A. Camarota, director of research for the Center for Immigration Studies, at 202/466-8185. The complete text of the study Camarota coauthored with James R. Edwards Jr. can be found on the Internet at* ***http://www.cis.org/.***

### The High Cost of COBRA

Newly unemployed workers may choose to continue their health benefits through COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), but they are in for sticker shock when they discover what their companies have been paying for health insurance.

A recent survey sponsored by the Kaiser Family Foundation found that, on average, employer-sponsored coverage in 2001 cost $7,056 for a family and $2,652 for an individual worker. HMO coverage cost somewhat less and traditional indemnity coverage quite a bit more.

In addition, health insurance premiums are going up faster than at any other time in the past 10 years.

- Employers are looking at premium increases averaging 20 percent in 2002, according to the William M. Mercer consulting firm.
- Even the federal government's health coverage is facing rate increases of 13.3 percent on the average, with some of the more popular plans going up 20 percent.

> **"On average, employer-sponsored coverage in 2001 cost $7,056 for a family and $2,652 for an individual worker."**

To exercise the COBRA continuation privileges, a laid-off worker must pay the premium plus a 2 percent administrative add-on. Since COBRA continuation premiums are subject to the same hikes as the underlying employer coverage, the $7,000 premium today may easily go up to $8,400 in 2002.

To add to the misery, the value of the coverage the worker was getting on the job was excluded from all taxes—state and federal, payroll and income. But the unemployed worker will get no tax assistance at all with the COBRA premium. Depending on his or her tax bracket, a worker will have to earn anywhere from $11,000 to $13,000 to pay the $7,000 family premium, once the taxes are taken out.

The cost to the government of excluding employer-sponsored health insurance from taxes was $140 billion in 2000—about 40 percent of the cost of benefits, according to Lewin and Associates. But for an unemployed worker, or a worker whose employer doesn't provide coverage, there is no assistance at all—no tax exclusion, no tax credit, not even a tax deduction unless the coverage costs more than 7.5 percent of the worker's gross income.

### Tax Credits for Everyone

Some of the proposals before Congress would provide refundable tax credits to people who are unemployed or whose employers don't provide coverage. These would provide some of the same tax advantages enjoyed by those who get coverage from their employers. However, most of the proposals would apply only to low-income people, so they would provide no assistance to most of the newly laid-off workers.

Congress could easily fix this by applying the tax credit to all workers who must pay for their own coverage. After all, the tax breaks given to employer-based plans have no income limits. In fact, the opposite is true: Higher-income workers get a far bigger tax break under current law than low- and moderate-income workers do.

### Medical Savings Accounts for Everyone

The other help Congress could offer would be extending Medical Savings Accounts (MSAs) to all Americans.

MSAs have been available since 1997, but only to the self-employed and employers with 50 or fewer workers. Airlines were not eligible, and laid-off workers are not currently eligible. Yet MSAs have two great advantages that would have helped airline and other laid-off workers, had they been eligible.

- They would have provided workers with a source of funds to pay for coverage while they are unemployed.
- They encourage insurers to offer low-cost, high-deductible insurance plans—an important option for the newly unemployed.

MSAs combine a tax-free savings account with a high-deductible insurance policy. The insurance covers serious medical conditions, and the MSA is there to pay for low-cost routine services. It allows people to conserve resources for times of need, because the money in the MSA can collect interest and build-up tax-free year after year.

This can be especially important when a worker can't afford to carry a Cadillac health insurance plan that covers everything. Rather than having to spend $600 a month to keep their insurance intact, laid-off workers might prefer a less-expensive plan that will cover them in case of emergencies.

### Policies for the Future

The terrorist-related layoffs have focused Washington's attention on the health care needs of the unemployed. But people are laid off, fired, or "downsized" all the time in the United States. They may have been lower-income or higher-income . . . but once they lose their jobs they all are no-income workers.

> **"The terrorist-related layoffs have focused Washington's attention on the health care needs of the unemployed. But people are laid off, fired, or downsized all the time in the United States."**

Current federal policy provides health care support for those who are working and making money, but as soon as they lose their jobs, the support evaporates. That is surely the most twisted aspect of our employer-based health insurance system.

Congress can do two things to help—right now.

- Extend the availability of Medical Savings Accounts to all Americans, so they will be able to build up a "rainy day" fund for their health care needs.
- Make refundable tax credits available to all who do not get coverage on the job and must pay for it directly from their own pockets.

President Bush and members of both parties in Congress support both actions. And both would help reduce the numbers of uninsured we are likely to see in the coming year.

*Greg Scandlen is a senior fellow in health policy with the National Center for Policy Analysis (NCPA) and assistant editor of* Health Care News. *This analysis was first published by NCPA on October 4 as* Brief Analysis #373.


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Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

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SUBSIDY continued from page 1

$11 billion available to help states to provide health insurance for low-income workers and their families in the S-CHIP program. It's an important opportunity for states to expand coverage to people whose lives have been severely affected by this September 11 attack."

The Department of Health and Human Services' (HHS) *Report on the Health Insurance Flexibility and Accountability Initiative* concluded that by 2006, 34 states are projected to spend less than three-fourths of their available funds. Fifteen states are expected to spend 100 percent of available funds, and nine states are expected to spend less than 15 percent of available funds.

The 10-page report adds the HIFA Initiative, first announced in July 2001, is "a promising new tool for states to use" to help reduce the number of uninsured by streamlining the approval process for Medicaid and CHIP waivers.

**"Conservative policy experts were quick to warn that increasing federal subsidies for insurance premiums could lead to health industry-wide price inflation."**

But Ron Pollack, executive director of Families USA, criticized Bush's flexibility proposal. Using CHIP money to provide assistance to recently uninsured adults would "take funds designed to provide coverage to low-income, uninsured children," he warned.

### No Unity Here

While Republicans and Democrats alike say they favor a multi-billion-dollar economic stimulus package, the *Washington Post* reports Democrats "swiftly rejected" the makeup of Bush's overall plan, saying it would "not provide enough money for individuals hurt by the economic slowdown."

Democrats are pushing a $16 billion package strictly for health care subsidies. In addition, Senators Edward Kennedy (D-Massachusetts) and Max Baucus (D-Montana) have proposed the federal government subsidize 50 percent of COBRA premiums for all affected workers and their families for up to 12 months.

They also want a new state option to cover, through Medicaid, workers in small businesses and others who are not eligible for COBRA. Families USA's Pollack, echoing the Kennedy-Baucus plan, said Bush should provide new federal funding by subsidizing COBRA premiums and covering those ineligible for COBRA through Medicaid.

Conservative policy experts were quick to warn that increasing federal subsidies for insurance premiums could lead to health industry-wide price inflation. In addition, increased participation in the Medicaid program could overwhelm a system barely able to serve the existing needy population.

### A Better Idea

A new measure offered by Rep. Bill Thomas (R-California), chairman of the House Ways and Means Committee, would help people buy health insurance, not subsidize it. The bill would allow laid-off workers to make penalty-free withdrawals from 401(k) and other savings plans to pay for health insurance premiums.

Under the measure, the normal 10 percent tax penalty on pre-retirement distributions would be waived for laid-off employees receiving unemployment compensation payments after September 10, 2001, and before January 1, 2003.

To be eligible, an employee would have to receive unemployment benefits for at least four weeks. The package also would give the states $3 billion to help laid-off employees pay for health insurance premiums, such as COBRA continuation coverage or coverage purchased in the individual insurance market.

The measure, H.R. 3090, also would extend by one year, to December 31, 2003, a federal law that allows small employers to offer tax-favored medical savings accounts—linked to high-deductible insurance plans—to their workers.

# Employers Embrace Consumer-Driven Insurance

*Defense contractor Raytheon will offer choice to 26,000 employees*

**BY CONRAD F. MEIER**

In a continuing effort to give employees more control over their health insurance coverage, defense contractor Raytheon Co. has chosen Definity Health as its insurance provider, becoming another in a growing list of employers offering defined-contribution health benefit plans.

Minneapolis-based Definity Health also provides coverage for Aon Corp. of Chicago, Ridgeview Medical Center of Wackonia, Minnesota, and the University of Minnesota, among others.

Starting in January 2002, Lexington, Massachusetts-based Raytheon will offer its approximately 26,000 employees in Texas and Arizona the defined-contribution-style plan managed by Definity Health. The program is designed to give employees greater freedom to choose the doctors and types of care they want. Employees also will receive information on wellness, prevention, and treatment, as well as data on pricing and the quality of local health care service providers.

Under the plan, employees choose their health care services and pay for them out of individual Personal Care Accounts, funded by employers at a set amount each year. Funds remaining in the account at the end of the year are rolled over for use in subsequent years.

The funding level for the accounts of Raytheon employees who choose the Definity Health option will vary depending on regional health care costs, in order to keep per-employee costs consistent across the company, a Raytheon spokeswoman said. She also noted Raytheon will continue to offer employees its other health plan options, including a point-of-service plan and health maintenance organization. Next year, Raytheon will add a preferred provider organization option.

### Health Care *A La Carte*

Across the country, a growing number of employers are using the 401(k) concept for employee health benefits: They're depositing their health insurance budget into flexible spending accounts and letting employees direct how the funds are used, just as they do their retirement investments.

The practice gives a new twist to defined-contribution plans, a term generally used to describe retirement plans. Employers are adopting defined-contribution health insurance plans for at least three reasons:

- to control insurance premiums, which are increasing at double-digit rates;
- to give employees more control over their health care benefits; and
- to allow employers to defend their businesses against the threat of expensive litigation.

For employers, the prospect of satisfying an aging and demanding population of employees—who are seeking ever-more-expensive life-enhancing benefits—is daunting.

According to Jean M. Wodarczyk, a partner with Pricewaterhouse Coopers in Chicago, employers will either make changes "around the edges" of their existing benefit systems or, more likely, will switch to different systems entirely, favoring those that give employees more responsibility for selecting and paying for their health care plan.

According to the *Health Care 2010* study published by the National Coalition on Health Care, experts tend to agree employers will gravitate toward defined-contribution-type health benefits. Employers will allocate a fixed amount to each employee, regardless of which plan the employee chooses or how much it costs. At least 60 percent of 380 top health care executives surveyed for the report said it's "very likely" employers will move to a defined-contribution system within 10 years.

### Not a New Concept

The defined-contribution approach isn't new. Most employers already pay a fixed amount for each employee's health care coverage, with employees picking up the remainder of the tab. Because the employer contribution is "defined," the employee's contribution varies according to the plan selected.

Managed care has slowed year-to-year medical cost increases in recent years. But with the return of double-digit health care inflation, employees will bear more of the cost burden. Employers will provide information on insurance policies, prices, and provisions, but give employees increasing responsibility for choosing how to spend their allocations.

Both new technology and new attitudes are partially responsible for the popularity of the defined-contribution model. Employees are already using the Internet for other types of health care information, making it an ideal medium for choosing health insurance.

Human resource professionals predict within five years workers will use the Internet to select from a rich mix of benefits ranging from catastrophic care to acupuncture. Empowered by access to health care information, consumers will find it easy to learn about and compare available choices and, from there, customize their own benefit packages.

**For more information…**

**WWW** about defined-benefit and defined-contribution models, especially as they relate to Medicare reform, see *Comprehensive Medicare Reform: Defined Benefit vs. Defined Contribution*, a September 1998 report from the National Coalition on Health Care. The report is available on the Internet at **http://www.americashealth.org/benefit_vs_defined.html.**

Or downloaded the report in Adobe Acrobat's PDF format from *PolicyBot*, The Heartland Institute's free online research service. Go to **www.heartland.org** click on the *PolicyBot* icon, and search for document #**3228423**.

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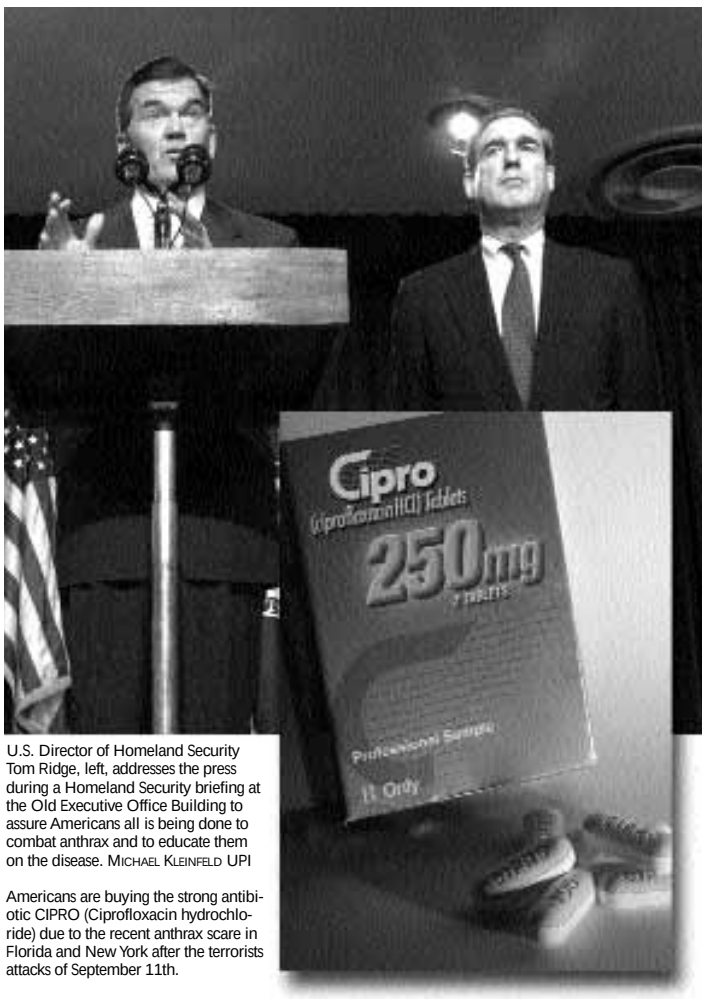
# ANTHRAX ATTACK?

## *Probably, but that's no reason to panic*




U.S. Director of Homeland Security Tom Ridge, left, addresses the press during a Homeland Security briefing at the Old Executive Office Building to assure Americans all is being done to combat anthrax and to educate them on the disease. MICHAEL KLEINFELD UPI

Americans are buying the strong antibiotic CIPRO (Ciprofloxacin hydrochloride) due to the recent anthrax scare in Florida and New York after the terrorists attacks of September 11th.

**BY RONALD BAILEY**

My first brush with "bioterrorism" occurred in 1997, when I was working as a television producer half a block from the B'nai B'rith National Headquarters in Washington, DC.

On April 24, a package leaking a red gelatin labeled "anthrax yersinia" was discovered in the B'nai B'rith mailroom. Police and emergency teams sealed off our street, and we watched from our building's roof as medics in sealed white "moonsuits" hosed down unfortunate B'nai B'rith employees in the middle of Massachusetts Avenue. Later we learned that 17 people had been taken to a local hospital for monitoring.

The red gelatin was tested at the Bethesda Naval Research Facility. It turned out to contain neither anthrax nor bubonic plague (yersinia). The "bioattack" was an anti-Semitic hoax, the perpetrator of which still has not been caught. Yet it cost more than $2 million to handle and was enough to close down a major thoroughfare less than a mile from the White House for 10 hours, disrupting normal activities in the city and spreading fear among its citizens.

The B'nai B'rith anthrax hoax is not by any means an isolated incident. The Monterey Institute of International Studies has been keeping track of recent terrorist incidents using chemical, biological, and nuclear materials. Their database shows that in the United States, all anthrax threats—34 in 2000 and 91 in 1999—were hoaxes.

### Florida in October: No Hoax

But the Florida incident was clearly not a hoax.

In October, Bob Stevens, a photo editor for American Media Inc. (AMI)—the parent company of the supermarket tabloids *The National Enquirer* and *The Globe*—died of inhalational anthrax. This is the worst form of the disease, in which victims are infected by inhaling spores of the anthrax bacteria; it kills at least 80 percent of its victims who do not receive antibiotic treatment before the onset of its flu-like symptoms.

Fortunately, anthrax is not contagious, so people who come in contact with an infected person are not at risk of contracting the illness. The Centers for Disease Control and the Federal Bureau of Investigation screened hundreds of AMI employees and discovered anthrax in the nasal passage of another person, 73-year-old Ernesto Blanco, who supervises the company's mailroom; Blanco was treated for flu-like symptoms at a Florida hospital. They also found anthrax spores on Stevens' computer keyboard. The AMI building was sealed, all AMI employees were tested for anthrax, and investigators combed the building for the source of the infection.

But doesn't anthrax occur naturally? Couldn't this be just a gruesome coincidence at a jittery time?

"It's pretty safe to say that the Florida incident is not a natural occurrence," says Claudine McCarthy, a research associate in the Chemical and Biological Chemical and Biological Weapons Nonproliferation Project at the Henry L. Stimson Center in Washington, DC. "You don't get anthrax in office buildings and on people's keyboards naturally." Eric Croddy, a research associate at the Monterey Institute, puts the chances that the outbreak is natural at less than 50 percent.

McCarthy's and Croddy's assessments are consistent with the Consensus Statement of leading experts on "Anthrax as a Biological Weapon" published in the May 12, 1999 issue of the *Journal of the American Medical Association* (JAMA). This document declared, "No case of inhalational anthrax has been reported in the United States since 1978, making even a single case a cause for alarm today."

McCarthy hastens, however, to point out that the Florida incident is a good example of what is much more likely to happen if terrorists actually use anthrax: A few people are exposed and harmed, but there is no widespread exposure or mass casualties. "It is much more difficult to use anthrax and other biological agents in mass attacks than is often suggested by the media," McCarthy notes.

Because of the difficulty in "weaponizing" biological agents, she concludes that even if the Florida incident does turn out to be some sort of attack, Americans have no reason to panic.

### Not Easily Turned into Weapons

Just how difficult it is to turn bacteria into weapons is illustrated by the case of the Japanese doomsday cult Aum Shinrikyo. In the 1990s, the cult, in an effort to spark an apocalyptic war between Japan and the United States, spent millions of dollars developing biological weapons. On eight different occasions, it tried but failed to spread anthrax and botulism throughout Tokyo with a rooftop sprayer and automobile exhaust systems. Frustrated, the cult then turned in March 1995 to Sarin nerve gas, which they released in plastic bags in the Tokyo subway, killing 12 commuters and making thousands ill.

"Most experts concur that the manufacture of a lethal anthrax aerosol is beyond the capacity of individuals or groups without access to advanced biotechnology," says the JAMA Consensus Statement. It then strikes a more worrisome note: "However, autonomous groups with substantial funding and contacts may be able to acquire the required materials for a successful attack."

Acquire the required materials from whom? After the Gulf War, the United Nations' inspectors found and destroyed 157 Iraqi aerial bombs loaded with various biological agents, including anthrax. Most experts believe Iraq is still engaged in producing biological weapons. According to Croddy, the Department of Defense has "intimated that Osama bin Laden has been seeking biological weapons for many years."

Preliminary information suggests the Florida anthrax strain is susceptible to being treated with penicillin. That means it is not one of the more dangerous versions created by weaponeers in the Soviet Union. If terrorists did acquire the Florida anthrax spores from an outside source, it may be possible to use genetic testing to trace the strain back to the original makers.

In addition, Croddy notes it would be relatively easy for a determined group to produce small amounts of anthrax spores that could be spread as non- aerosols, perhaps through the mail.

> **"After the Gulf War, the United Nations' inspectors found and destroyed 157 Iraqi aerial bombs loaded with various biological agents, including anthrax."**

### "Don't Panic"

Even if it turns out that, as unlikely as it seems, the Florida outbreak has a natural explanation, there is little doubt would-be terrorists will be issuing further anthrax and other bioterrorism threats in the future as a way of trying to sow uncertainty and panic. So what to do?

"First, take a deep breath and don't panic," advises the Stimson Center's McCarthy. "Whatever is happening in Florida is not indicative of a massive attack nor does it point to the possibility of such attacks. Panicking is what the terrorists want us to do." She notes that since the despicable attacks on September 11, the U.S. public health system has been on very high alert, monitoring to make sure any biological attack is quickly detected and contained.

Other experts warn Americans against promiscuously using antibiotics like ciprofloxacin (Cipro) on a continuing basis in a misguided effort to ward off an unlikely anthrax attack.

The bottom line? "I live in Washington, DC. I don't have a gas mask and I take the Metro every morning to work," says McCarthy. "It's a risk leaving your house to go to work every day. The remote possibility of a bioterrorist attack isn't worth worrying about."

*Ronald Bailey is a science correspondent for Reason. Reprinted, with permission, from Reason Online. Copyright 2001 by Reason Foundation, 3415 South Sepulveda Boulevard #400, Los Angeles, CA 90034. www.reason.com*

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# University to Study Health Care at Mexican Border

BY CONRAD F. MEIER

Health and Human Services Secretary Tommy G. Thompson announced the department has awarded a $250,000 research grant to the University of Texas Health Science Center at San Antonio. The initial investment is for a five-year agreement to establish a Regional Center for Health Workforce Studies at the school.

The new center will study how access to health care is affected by the quality and quantity of the health care workforce along the U.S.- Mexico border and in the south central United States.

Thompson explained in a news release announcing the award, "The new UT-San Antonio research center will help us develop effective strategies for attracting the right mix of doctors, nurses, and other health care professionals to serve the people who live in the border region."

The grant, according to Thompson, "is part of our broader commitment to improving access to health care for children and families in this underserved area."

> **"The new UT-San Antonio research center will help us develop effective strategies for attracting the right mix of doctors, nurses, and other health care professionals to serve the people who live in the border region."**
>
> TOMMY THOMPSON, SECRETARY
> DEPARTMENT OF HEALTH & HUMAN SERVICES

## Border Issues

The new regional center is part of the Border Health Initiative, led by the department's Health Resources and Services Administration (HRSA), created to improve health care access for people in the U.S.-Mexico border region.

The region is characterized by high poverty, poor environmental conditions, and significant health challenges. As an example, tuberculosis at the border is six times the national rate; measles and mumps are preventable, but the incidence rate at the border is twice the U.S. average. About 3 million of 11 million border residents have no health insurance. Many residents live in unincorporated communities that lack running water, sewers, storm drainage, and electricity.

In the past four years, HRSA has invested $280 million to improve health care along the border, including roughly $83 million in fiscal year 2001. Those resources have provided residents with primary health care, maternal and child health care services, HIV/AIDS care, and other services. HRSA has also supported programs to train and place health professionals in the region.

## Finding Out, Reaching Out

The new center at San Antonio will assess some of the most pressing health workforce issues in the region. These include examining regional staffing levels for physicians, nurses, dentists, public health, mental health, and allied health professionals; placement of those professionals throughout the region; training needs; and recruitment and retention. The agreement recognizes the difficulties border residents face and the role local researchers can play in improving conditions.

HRSA Acting Administrator Elizabeth M. Duke said, "The first step in improving access to care in the region is to find out how many health care workers we have, what disciplines they work in, and where they are located. Then we can put together a strategy to encourage providers to work where the need for their services is greatest."

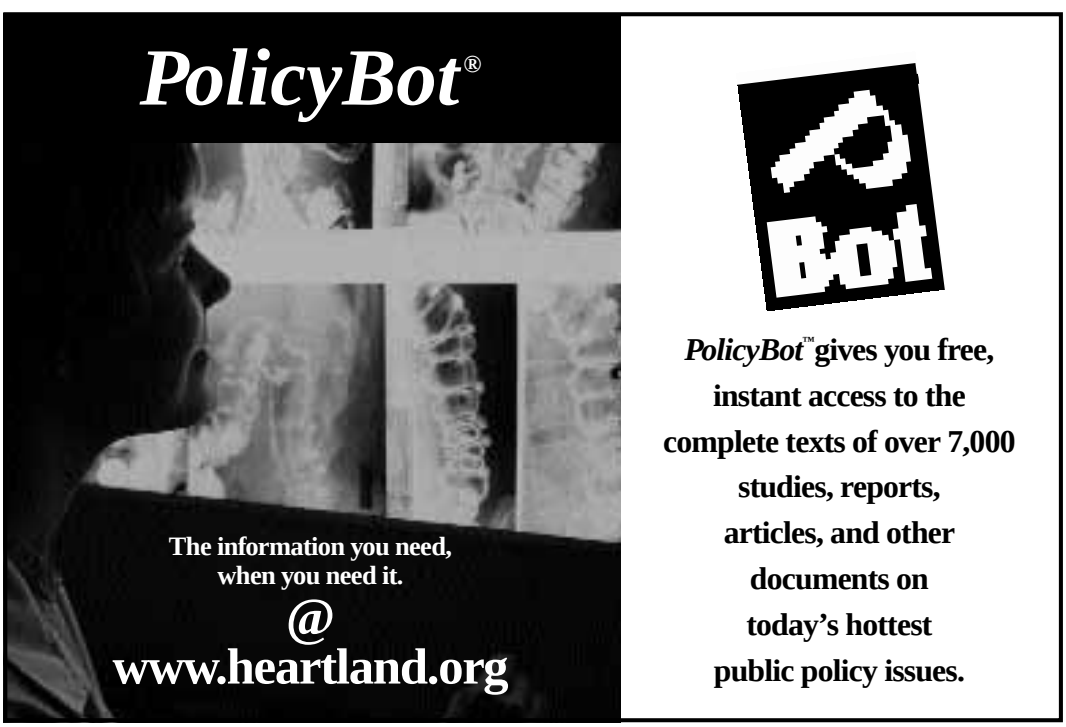
HRSA is also making available copies of *Diario de Salud*, a diary for expectant mothers who speak Spanish, with an updated vaccination chart. The diary was developed to help expectant mothers have a healthy baby and presents information about childbirth from conception through the age of 2. It includes fill-in-the-blank forms the mother can complete as her pregnancy progresses. Copies are available by calling 1-888-ASK-HRSA.

Thompson noted in the news release that HHS will renew competitive cooperative agreements at the four existing regional centers—University of California at San Francisco, University of Illinois at Chicago, State University of New York at Albany, and University of Washington, Seattle—currently conducting workforce studies for much of the rest of the United States.

**For more information…**

WWW visit **http://bhpr.hrsa.gov/healthworkforce/**. An HRSA factsheet with more information about the Border Health Initiative is available at **http://newsroom.hrsa.gov/factsheets/borderhealth2001.htm**.

Tommy Thompson (right), U.S. Secretary of Health and Human Services, and Mexican Health Minister Dr. Julio Frenk (left) sign the U.S.-Mexico Food Safety Agreement at a September 4 ceremony in Washington, DC. HHS has announced funding for a new research center to study health care along the U.S.-Mexico border. PHOTO: UPI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GALEN INSTITUTE

# THE GALEN REPORT

*A monthly review of health policy matters*

The warning from all quarters, including HHS Secretary Tommy Thompson, is to avoid complacency, since the current economic downturn will mean many more people will lose health insurance coverage this year.

John Desser of the Coalition for Affordable Health Coverage has urged policymakers to increase options for SCHIP dollars to be used for private coverage, including tax credits for the purchase of private health coverage.

**"President George W. Bush and congressional leaders say they want to finish work on the misguided patients' bill of rights. Passing this bill will certainly exacerbate future increases in the number of uninsured."**

The Coalition for Affordable Health Coverage was launched in early October, showing broad support in the business community for solutions to help the uninsured obtain private health coverage. Kate Sullivan of the U.S. Chamber also advocates strengthening and expanding the current market-based system, recommending tax incentives for individuals who buy their own health insurance, including refundable tax credits for those with low incomes.

Jeff Lemieux of the Progressive Policy Institute has been advancing an idea to provide tax credits to displaced workers to continue their health coverage through COBRA. But why not give workers a choice of using the credit either for COBRA or for any other coverage they may choose?

### Health Care Costs Rising

Last month, a study by the Center for Studying Health Systems Change found that health costs jumped 7.2 percent last year. Inpatient and outpatient hospital care, not prescription drugs, led the increase, accounting for 47 percent of the overall increase in health care costs in 2000. (See story page 10.)

So far, employers are absorbing most of the costs. But with the economic dislocations following the September 11 catastrophes, it will be difficult for them to continue doing so.

Adding to the problem, President George W. Bush and congressional leaders say they want to finish work on the misguided patients' bill of rights. Passing this bill will certainly exacerbate future increases in the number of uninsured. By threatening employers who provide health coverage with lawsuits, many are likely to drop coverage.

The Consensus Group met in early October to try to assess the new policy landscape. We explored a number of options to help in these difficult economic times, including: targeting tax credits to individuals and families regardless of where they get their insurance; ending the use-it-or-lose-it provision for Section 125 health spending accounts, beginning with displaced workers; expanding and fixing Medical Savings Accounts; and easing the way for companies to shift to models of health coverage that give employers and employees more control over choices and costs.

Finally, many Consensus Group members and hundreds of others attended the memorial service for Norma Steuerle, wife of our colleague Gene, at Blessed Sacrament Church in Alexandria. It was a powerful reminder of the terrible loss that the Steuerle family and all of Norma's friends and clients have suffered. And to multiply this loss by more than 5,800 is too much even to comprehend. Keep them and our country in your prayers.

*Grace-Marie Turner*

## RECENT NEWS & PUBLICATIONS

### How Congress Can Help the Uninsured Obtain Health Coverage

*Nina Owcharenko*
*The Heritage Foundation*

Refundable tax credits are the "broadest and most effective" way to help the uninsured, says Nina Owcharenko of The Heritage Foundation. This paper examines the problems with current federal programs, the benefits and impact of tax credits, and the current legislative proposals for tax credits. Nina also describes the key elements for an effective tax credit proposal, saying the credits must be individualized, refundable, transferable, and meaningful.

http://www.heritage.org/library/backgrounder/bg1475es.html

### Health Insurance Tax Credits for Workers: An Efficient and Effective Administrative System

*Lynn Etheredge*
*Health Insurance Reform Project*
*September 2001*

In this new paper, Lynn Etheredge outlines a system for administering health insurance tax credits to workers. The plan features payroll deductions and automatic enrollment, "proven methods to yield high enrollment at low costs," he writes.

Etheredge describes his model system in the following way for a worker eligible for a $1,000 credit:

A new worker elects a health insurance plan and determines the amount of the payroll deduction to pay the balance of the premium. The employer notifies the health plan and forwards the payroll deductions via a service center. The health plan then notifies the Treasury Department and is paid the $1,000 tax credit. The worker then has insurance of his or her choosing with financing administered through the employer.

http://www.gwu.edu/%7Ehirp/intros/Publications.htm

### Waiting Your Turn: Hospital Waiting Lists in Canada

*Michael Walker with Greg Wilson*
*The Fraser Institute*
*September 25, 2001*

The Fraser Institute has released its 11th annual survey of waiting time for surgical and other therapeutic treatments throughout Canada. The study finds that despite large increases in federal spending on health care, the wait times for treatment have increased from 13.1 weeks in 1999 to 16.2 weeks in 2000.

Walker describes the increase this way: "Canada-wide total waiting time increased significantly in 2000-01, and its level is high, both historically and internationally. Compared to 1993, waiting time in 2000-01 is 69 percent higher. Moreover, academic studies of waiting time have found that Canadians

wait longer than Americans, Germans, and Swedes (sometimes) for cardiac care, although not as long as New Zealanders or the British."

http://www.fraserinstitute.ca/publications/critical_issues/2001/wyt/sect ion_03.html

### Man Calls Emergency Room Home

*David Foster*
*Associated Press/LA Times*
*September 23, 2001*

Foster's article tells the story of Gregory Goins—a jobless, penniless man with health problems but no health insurance or Medicaid coverage. Goins has visited Highland Hospital's emergency room more than 1,200 times since 1996. His transportation by ambulance and emergency room visits have cost taxpayers approximately $900,000.

Foster says, "His case, while extreme, is rooted in a widespread problem: America's emergency rooms face a growing crush of patients, many uninsured and lacking other access to medical care. Among them are regular visitors who look to emergency rooms to provide food, human interaction or perhaps just a warm place to sit for a while."

http://www.latimes.com/news/printedition/california/la-000076371sep23.story

*The Galen Report is a monthly review of health policy matters provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320. Grace-Marie Turner is president. The report is compiled by editor Elizabeth Turner, who can be contacted at 703/299-9550. Or visit The Galen Institute Web site at http://www.galen.org.*

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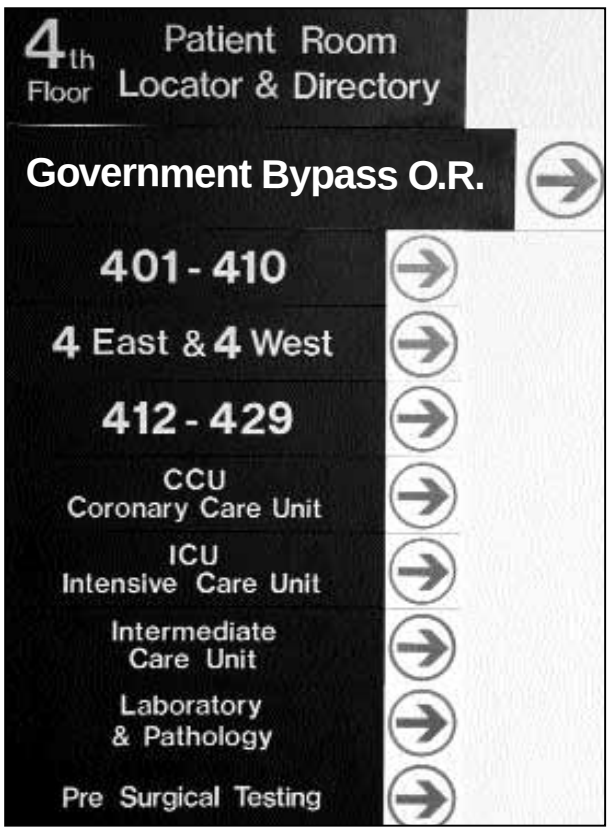
# A Regulatory Bypass Operation

*The country's health insurance industry needs a heavy dose of consumer choice and a lot less federal government*




**BY TOM MILLER**

Despite the 1994 demise of then-President Bill Clinton's national health care proposal, we've witnessed increasing federal regulation of health insurance.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) applied yet another regulatory band-aid to problems caused by previous public policy errors. The system of federal and state regulation set in motion by HIPAA will inevitably drift toward increasing federal government involvement, and will also encourage a state race to the bureaucratic top.

More recently, this year's Senate version of the Patients' Bill of Rights suggested a new role for federal solvency regulation of health insurers. Federal regulators want to make certain the insurers' pockets won't be completely empty . . . at least not until *after* they've paid off the attorneys' fees and judgments that will result from the lawsuits the bill will authorize and encourage.

## New Arteries for Reform

Our health insurance system is increasingly burdened by thickening globs of regulatory sclerosis. It's time to open up some new arteries for consumer-driven health care reform.

Step one in the regulatory bypass operation is diagnosis of the underlying condition: Consumers are not in control of their health care decisions. Public policy discourages them from retaining control of their health care dollars and hinders the availability of empowering options in the marketplace.

Step two requires that we move out of the box of conventional palliative therapy and address fundamentals. First and foremost, policymakers must neutralize the distorting effects of the income tax exclusion that favors employer-financed group insurance.

Any tax subsidy for health care spending should be available to all consumers, and it should flow directly to them—regardless of where they work or how they choose to purchase health care. Tax benefits for health coverage must be made portable at the individual level.

Current tax subsidies often operate as tax penalties on consumers seeking other types of coverage, whether it's individual insurance, high-deductible policies coupled with personal saving vehicles, or simply different coverage than what one's employer offers.

Tax equity would provide consumers with real choices in their health care arrangements and would decentralize decision-making. Consumers would be less likely to turn over to third parties key decisions regarding the scope and terms of their health insurance coverage. Preventive care? Dental or vision coverage? Low monthly premiums? The right to see any doctor, at any time? Those are the kinds of decisions *consumers*—not third parties—should be making for themselves and their families.

## The Operation Continues

Step three is to develop better vehicles to pool health risks outside of the workplace, and to provide longer-term protection against the redefinition of health risks over time.

The best way to address the risk definition concerns of buyers in the individual and small-group markets is *not* through politically mandated pooling, with all risks—male and female, young and old, healthy and unhealthy—forced to pay the same premium. Instead, non-government purchasing pools could offer experience-rated, multi-period contracts to willing buyers, if pool sponsors can establish necessary ground rules.

Those rules would allow competing health plans to set their own premiums; experience-rate new entrants to the pool at the outset, if necessary; facilitate entry of new insurers to compete for pool business; and provide annual open enrollment periods.

Such purchasing pools would differ from the early versions of association health plan and health mart proposals. They should not be limited just to employers making collective decisions for all their employees. Individuals should be permitted to join the pools as well.

Pre-specified contractual restrictions would provide incentives for people to remain in the purchasing pool once enrolled. Exit disincentives would provide long-term protections and minimize adverse selection. Actuarially fair prices would be required at the outset.

Step four—and it's a crucial step in the process—is to recognize the diverse preferences, characteristics, and needs of individual consumers. Respect the decisions they make. Enforce private contracts as they are written. Don't prohibit risk-based pricing. Rely instead on targeted and transparent subsidies if market-set prices and coverage options don't address the needs of low-income, medically high-risk, or other specific groups of people.

Of course, the Patients' Bill of Rights legislation is poised to outlaw or override what remains of the already paltry and unimaginative contractual options available in today's private health insurance market. Regulatory mandates, along with "judge-made insurance," already discourage most efforts by insurers to stray very far from the medical community's consensus view of what insurers should finance ("medical necessity"). Insurers these days are responding to the demands of judges and the medical profession, instead of offering *consumers* a range of coverage options that vary in quality, access, and pricing.

Accurate risk assessment often conflicts with the politicians' desire to control the distribution of risk. But the problems of inadequate income to purchase insurance, or health conditions making someone medically uninsurable, can and should be addressed as *social* problems. Safety net subsidies, private charity, community-based clinics, and high-risk pools—not insurance—are the right mechanisms for addressing social problems.

## Heading Off Regulatory Attack

The band-aid of increased federal regulation cannot cure what ails our health care system: an unstable structure of already over-regulated and over-subsidized employer-based health insurance.

Still further reliance on the federal government will burden the health care industry with a "one size fits all" regulatory framework resistant to competitive pressure. It would be prone to deliver just one "cure," of comprehensive scope, likely to be the wrong one but difficult to reverse.

Which brings us to step five in the regulatory bypass operation. We need revitalized state regulatory competition that can reach across geographic boundaries.

Such *competitive federalism* could facilitate diversity and experimentation in regulatory approaches. It would slow down the second-guessing of market decisions, discipline the tendency of regulation to promote inefficient wealth transfers, and promote individual choice over collective decisions driven by interest group politics.

Insurers facing market competition across state lines would have strong incentives to disclose and adhere to policies that encouraged consumers to deal with them. Firms would migrate to state regulatory regimes that didn't impose unwanted mandates but instead fit the needs of their customers. State lawmakers would become more sensitive to the possibility that over-regulated insurers would take their business elsewhere.

> **"Insurers these days are responding to the demands of judges and the medical profession, instead of offering consumers a range of coverage options that vary in quality, access, and pricing."**

## Competing Regulatory Regimes

State competition in health insurance regulation could be achieved through choice-of-forum clauses, and perhaps choice-of-law clauses, in insurance contracts.

Insurers would specify in each policy the state whose laws would govern that policy. Consumers, by purchasing a specific policy, consent to that choice of governing law. Policies purchased in Wisconsin, for example, wouldn't necessarily be governed by that state's laws. The insurer might offer a more expensive policy governed by the laws of regulation-heavy Illinois, and a less-expensive one governed by the laws of regulation-light New Jersey. Consumers who believe there are advantages in new and different regulatory approaches would be allowed to try them.

Critics of such competitive federalism will warn that a "race to the bottom" will take place, that states will offer the most lax, least expensive regulatory regime possible, leaving customers at the mercy of evil insurers.

Those critics fail to acknowledge we've already run a race to the bottom with over-regulation. The losers end up uninsured—because they can't afford coverage, or because they refuse to overpay for it.

The race to the market top needs a full field of healthy state regulators running in each other's markets. The five-step bypass operation prescribed here would get consumers, insurers, *and* state regulators in shape for that race—and everyone wins.

*Tom Miller is director of health policy studies at the Cato Institute and contributing editor to* Health Care News.

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My Turn

# Stop Demonizing the Good Guys

BY CONRAD F. MEIER
MANAGING EDITOR

Before September 11, President George W. Bush and many members of Congress promised to make prescription drug benefits part of Medicare. Given the current state of the union, the timeline has moved to next year.

But some relatively little-known free-market programs offered by virtually all pharmaceutical manufacturers have been making it easier to afford medications for many years.

> **"Instead of the incessant demonizing of the pharmaceutical industry, we should pause to reflect on the incalculable good those firms have accomplished so far."**

More than 60 drug manufacturers have what can be best described as "patient assistance programs." Those programs make it more affordable for Medicare recipients, especially those with low incomes, to buy their prescription medications.

Pfizer, for example, provided free—not discounted, but free—drugs for 600,000 people last year.

Through their assistance plans, drug companies provide free medicines for those who have no prescription drug coverage and whose incomes fall below certain levels, regardless of age.

The income limits are not at all strict, and in some cases people earning up to $50,000 a year can qualify. One unavoidable step is you must apply separately to each company making your medications. The drugs are usually dispensed by doctors, and patients have to re-qualify regularly. A little bit of personal effort here goes a long way toward saving money.

### Little Awareness

The drug makers do not brag about this charitable endeavor and they do not advertise their programs. Some doctors are unaware of the programs, and others don't want to get involved because of the potential paperwork. Due to a lack of media coverage, most Americans are unaware of this assistance.

You needn't pay for information about these pharmaceutical assistance programs. A directory of pharmaceutical companies offering such plans, along with information on eligibility requirements, is available free of charge from the Pharmaceutical Research and Manufacturers of America (PhRMA) Web site. The 2001-2002 directory is available at http://www.phrma.org/searchcures/dpdpap.

### More Upbeat News

A recent PhRMA survey found there are 261 new drugs in development aimed at diseases affecting senior gals and guys like me. New medicines in the pipeline for Alzheimer's disease, osteoporosis, arthritis, and Parkinson's disease are among the many promising treatments in development for these and other diseases of aging, according to a new survey released in October 2001.

All told, there are now 785 medicines in the development stage designed to enhance longevity and improve the quality of life. There are 402 medicines in development for cancer and 122 in development for heart disease/stroke. All of the potential medicines are either in clinical trials or awaiting final approval by the Food and Drug Administration.

> **"Our aging populace underlines the need for prescription drug coverage for seniors, who expect and deserve access to the fruits of medical research."**
>
> ALAN F. HOLMER, PRESIDENT
> PHARMACEUTICAL RESEARCH AND
> MANUFACTURERS OF AMERICA

"This promising research on diseases of aging comes at a time when the elderly population is growing at an unprecedented rate," said PhRMA President Alan F. Holmer. "Our aging populace underlines the need for prescription drug coverage for seniors, who expect and deserve access to the fruits of medical research. Medicare drug coverage must be crafted in a way that gives seniors access to the medicines of today and provides incentives for companies to discover the medicines of tomorrow."

### Doing the Right Thing

The country's leading research-focused pharmaceutical and biotechnology companies have invested a combined total of more than $30 billion in 2001 in an effort to discover and develop new medicines. If now is not the time to give credit where credit is due, when is it?

Instead of the incessant demonizing of the pharmaceutical industry, we should pause to reflect on the incalculable good those firms have accomplished so far. Every successful attempt to tax away to reduce profits will eventually weaken the research and development component of the firms' work. In the end, it will be the consumer who loses.


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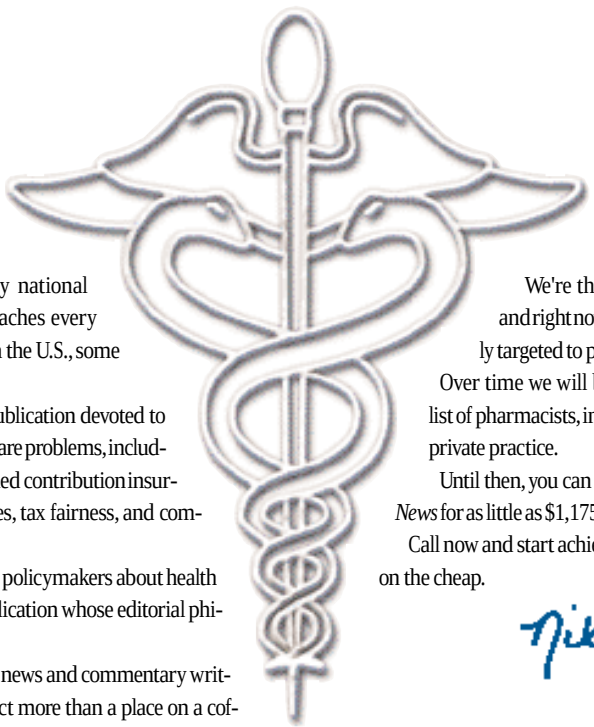

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